The Effect of Risk-Based Mental Health Law on Access to Mental Health Services

A thesis submitted for the degree of Doctor of Philosophy of The Australian National University

by

Maree Livermore
October 2016

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I declare that the work in this thesis is entirely my own and that to the best of my knowledge it does not contain any materials previously published or written by another person except where otherwise indicated.

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October, 2016

Canberra, Australia

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I would like to thank my principal supervisor, Professor Beverly Raphael, for her warmth, her unfailing confidence, and for her enduring personal support over the course of this PhD. My sincere thanks also to my associate supervisor, Emeritus Professor Terry Carney AO, for his strong commentary on the work throughout, and especially for his support and encouragement in its final stages.

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This thesis is dedicated to my dear Dad, Brian Livermore, who passed away in the middle of my candidature, and to my much-loved mother and friend, Joan Livermore, who died only recently. In the final stages of her illness, she continued to proof-read, to argue with me about forms of expression, and to teach me invaluable lessons.
Abstract

The escalating personal, social and economic costs of poor access to effective mental health services in Australia now demands ‘root-and-branch’ re-evaluation of Australian mental health policy, and the structure of the public mental health system— including one of its central pinions, mental health law.

There is continuing debate about the clinical, ethical and rights-based rationale for the long-standing model of risk-based mental health law. To date, this has not included the examination of its effectiveness as an instrument of policy. This thesis adopts a regulatory governance perspective overall, to examine the effect of the risk-based model of mental health law on one of its principal express purposes—facilitating access to mental health treatment. The question is addressed in the light of competing perspectives in the literature. These include the dominant discourse, as represented in the law itself, that risk criteria in the law facilitates access to mental health services. They include, also, arguments favouring the hypothesis that risk-based mental health law inhibits access to effective mental health service.

The thesis describes the development and application of a novel, mixed-model, social policy analysis framework. It integrates a network governance sub-study and a realist governmentality sub-study, with additional formal scoping and synthesis phases. The literature-based network governance sub-study engages a modified critical interpretive synthesis method. The realist governmentality sub-study combines discourse analysis and ethnographic fieldwork, entailing semi-structured, recorded and transcribed interviews with 28 public psychiatrists in five Australian mental health jurisdictions, in a genealogical analytic.

The study found that minimising costs and criticism in the electorate were much higher-priority concerns for the state than facilitating access to service. The study revealed significant evidence of governmental strategies to regulate the action of public psychiatrists to support this order of concerns.

There was evidence of both compliant and resistant responses by psychiatrists to these strategies. Both types of responses were found to engage mental health law formally—in practice and for purposes as intended by the legislature—but also informally, for other purposes, and with ‘creative’ interpretation.

It was found that mental health law is formally engaged, in practice, to ‘responsible
public psychiatrists to provide risk-focussed usual care. It is used informally to enforce informal triage practices, especially a range of gate-keeping mechanisms; to support blame and accountability mechanisms leveraged against psychiatrists; and for the medico-legal protection of the state and psychiatrists.

Access-negative effects to which these practices contribute include: denial or discontinuance of needed public psychiatric care; non-provision of traditional, holistic, individualised, effective psychiatric therapy; waste of psychiatric time and expertise; and high-levels of despair amongst psychiatrists.

The results support the discourse that the risk-based model of mental health law prevailing in many Western jurisdictions—including in New South Wales, Victoria and the Australian Capital Territory—does not ‘work’ in relation to its object to facilitate access. The central and growing problem of mental illness in the Australian community will likely worsen if it remains in the care of a public mental health service system built around this non-performing regulatory technology.
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CHAPTER 1: INTRODUCTION

So in [jurisdiction] it’s apparently really easy: “Are you going to kill someone? No? Sorry, piss off. Even if you’re not well, it’s [already] three days, so you’ve got to go”.

So, you know, from a systems point of view, it’s just the easiest gig: “It’s not my fault. It’s just the law. I can’t do anything about the law”.

*Male psychiatrist informant, Phase III governmentality sub-study*

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The premise for this thesis is situated at the intersection of two significant problems within the Australian mental health policy domain. The first is the rising personal, social and economic cost of inadequate access to effective, timely and appropriate mental health services. The second issue, not prominent in public discussion but the subject of lively debate amongst policy-makers, psychiatric clinicians and academics, concerns the rationale for continuation of the risk-based model of mental health law.

The problem of access
The improvement of access to mental health care has been an expressed policy goal of Australian governments for almost two decades, and yet the tide of concern about unmet demand for mental health services within the community seems only to increase. Despite formal expressions of intent via a national mental health strategy, a national action plan, and no fewer than four national mental health plans to date (with another in preparation), stakeholders in the sector continue to report major shortfalls in service delivery (Lane & Barbour, 2015; Mental Health Council of Australia, 2005; UBM Medica, 2010).

The problem of risk-based mental health law
Each Australian state and territory retains a mental health law that expressly aims to facilitate access to treatment for people with serious mental illness. These laws are expressly purposed, also, to protect the rights of people with mental health conditions, and to prevent harm caused by them. The eligibility of a particular consumer for the action of the law associated with any of these objectives, in all Australian jurisdictions, includes satisfaction of ‘risk-of-harm’ criteria.

In recent years, there has been mounting criticism of mental health law structured around risk-of-harm criteria, mobilised across a number of intellectual bases—including in the human rights, medical ethics and clinical spheres. There has been relatively little attention paid to the efficacy of mental health law as an instrument of policy.

Risk-based mental health law as an instrument of policy
This thesis examines the effectiveness of risk-based mental health law in relation to an important part of its rationale for existence, the facilitation of access to treatment.

Methodology
The methodology for the study features a network governance approach—to explore the salience of the access objective in the complex mental health policy domain; and a contemporary governmentality approach—to profile the real-time, real-place, real-people effects of risk-based mental health law in Australia. These two approaches are integrated
and synthesised in a novel, four-phased mixed-model methodology.

**Structure of this chapter**

The balance of this Introduction profiles the problems of access to mental health services, and of mental health law, and, importantly, as the pretext for the investigation documented in this thesis, what is at stake in the relationship between the two. It further clarifies the research focus and definitions, and outlines the basis, boundaries, limitations, and epistemological and disciplinary challenges of the methodology.
1.1 THE AUSTRALIAN POLICY PROBLEM OF ACCESS TO MENTAL HEALTH SERVICES

The first section of this thesis investigates the social, political, epidemiological and demographic factors underpinning construction of the problem of ‘poor access to mental health services’ as it is represented in Australia today. These issues suggest complexity in the notion of access and its relation with mental health need, demand, service and the evidence base.

1.1.1 THE SCOPE AND COSTS OF INADEQUATE ACCESS

Significant failure in provision for access to many different types of mental health services, for many different sectors of the population of people with mental health difficulties, has been repeatedly documented. Despite this, the economic, social and personal costs of poor mental health in the Australian community continue to escalate.

Prominence of mental ill-health in the epidemiological profile
Poor mental health features significantly in the total fabric of health issues amongst Australians. In 1996, mental problems or disorders were responsible for over 13 per cent of Australia’s disease burden, in terms years of life lost due to premature death, as well as years of healthy life lost (Mathers, Vos, Stevenson, & Begg, 2001, n.p.). By 2003, this had risen to an estimated 24 per cent (Australian Institute of Health and Welfare, 2009, p. 4).

ReachOut.com and Ernst & Young reported in 2014 that, in every year, 3.2 million Australians—one in five—suffer from a diagnosable mental illness. Only 1.1 million—representing fully 35 per cent of the total population of people with mental illness—receive professional help. An additional 25 per cent are under-served (Hosie, Vogl, Hoddinott, Carden, & Comeau, 2014, p. 8).

Economic costs
Costs in health and non-health public expenditure supporting people with mental illness are almost AUD$30 billion per annum (and this figure excludes the cost of lost productivity and capital expenditure) (Mendoza, 2010; Nous Group, 2014, p. 9-10).

A crisis in demand
There are repeated claims of crisis in the mismatch between demand for and supply of access
to services in the Australian mental health system (Burdekin, 1993; Lourey, Holland, & Green, 2012; Mental Health Council of Australia, 2005; National Mental Health Commission, 2013). In 2010, it was reported that more than 1,200 people per day were refused admission to a public or private psychiatric unit, and that, every day, three of the seven Australians who die of suicide had, at some stage, been discharged early or without care after hospitalisation for mental health needs (Mendoza, 2010, n.p.).

Specific services reported to be in high demand and short supply include:

- hospital-based acute care beds (McGorry, 2010; Mental Health Council of Australia, n.d.; Rosenberg, 2010; Senate Finance and Administration References Committee, 2010);
- community-based clinical services (Senate Finance and Administration References Committee, 2010);
- non-clinical support services such as support in housing, employment and psychosocial services (Jablensky et al., 2000; Steering Committee for the Evaluation of the Second National Mental Health Plan 1998-2003, 2003) and to assist disadvantaged and disabled consumers in travel to and communication with service providers (Mental Health Council of Australia, n.d.).
- services for physical ailments suffered by mental health service consumers (McGorry, 2010; Mental Health Council of Australia, n.d.); and
- services to treat co-morbid substance abuse.

Specific groups of consumers of mental health services, or would-be consumers, who suffer particular disadvantage in achieving access to mental health service include:

- people suffering from economic disadvantage (e.g. those unable to pay the ‘gap’ for private clinical care) (B. J. Burns et al., 2004; Kelly, 2006);
- consumers suffering from mental disorders in corrective facilities (Mental Health Council of Australia, n.d.; United Nations Human Rights Council, 2010);
- children and youth (Raphael, 2010; Steering Committee for the Evaluation of the Second National Mental Health Plan 1998-2003, 2003);
- people of culturally and linguistic diversity and Australia’s Indigenous peoples (Hosie et al., 2014);
older people (Steering Committee for the Evaluation of the Second National Mental Health Plan 1998-2003, 2003);

- people living in rural areas (Caldwell, Jorm, & Dear, 2004), and

- lesbian, gay, bisexual, transgender and intersex young people (Hosie et al., 2014).

The architecture of the Australian mental health access problem
In considering a revised policy approach to the problem of access to mental health service, it is instructive to consider its historical trajectory. John Petrila did this, in 1992, considering ‘a new agenda’ for US mental health law that included improved access to service. He described five distinct socio-political changes in the American system that had affected access to service: significant changes in reimbursement systems presenting as barriers to access; developments affecting the psychiatric hospitalisation of children; the Clozapine ‘controversy’; new research into links between housing and involuntary commitment, and the rise of consumer and family movements in mental health.

The Australian ‘story’ of the problem of access, as read in 2015, is quite different. Some of its principal elements will be briefly outlined in the sections that follow. These include: the idiosyncratic Australian experience of de-institutionalisation, practical problems arising from the distribution of funding and servicing responsibilities, and the problem of defining and measuring access.

1.1.2 THE AUSTRALIAN EXPERIENCE OF DE-INSTITUTIONALISATION

‘De-institutionalisation’ is a term commonly used to describe the policy direction away from institutionalised, residential care and towards community-based care of people with mental health conditions. It has been claimed that the current problems with access to the mental health system in Australia arise from a stalled policy of de-institutionalisation (Rosen, 2006).

Commencement of de-institutionalisation
The trend to de-institutionalisation was initiated informally, largely as a series of political decisions from the 1970s onwards to deny funds for upgrades to outdated residential facilities, and as a public response to scandals and enquiries around long-term residential facilities such as the Chelmsford hospital in New South Wales (NSW) (Rosen, 2006). Specific, formal de-institutionalisation policy was first represented in the response to the
Richmond report of the *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled* with a decision of the NSW Government in 1984 to fund community-based mental health resources as an alternative to institutional care. At the same time, general hospitals were encouraged to adopt the necessary security measures to accommodate acute psychiatric patients subject to involuntary orders.

**De-institutionalisation nationally**

Formal policy towards de-institutionalisation progressed into the national sphere in 1992 with the advent of the first National Mental Health Policy and accompanying National Mental Health Strategy. These strategy plans promoted a funding shift from institutions to community-based facilities, and the ‘mainstreaming’ of mental health patients through general health facilities (Rosen, 2006). The outcome was a drastic reduction in hospital-based, acute, mental health beds.

Since the commencement of de-institutionalisation, there has been no concomitant funding and development in the community sector to replace the services previously provided in institutions, or to provide for the increase in demand occurring through population changes and other causes of increased demand across the period (Groom, Hickie, & Davenport, 2003; Jablensky et al., 2000; National Mental Health Summit, 2010; Whiteford & Buckingham, 2005). Speaking at the Australian Senate’s *Inquiry into Mental Health Services* in 2010, Mr David Crosbie, Chief Executive Officer of the Mental Health Council of Australia, painted a stark picture of the depth of the structural change:

> We need the community programs in place that we have really run down, if anything, since we closed all the institutions. We had 30,000 acute beds for eight million people in the sixties… We are down to 8,000 acute beds for double that population and we have halved the number of community beds.  

*(Senate Finance and Administration References Committee, 2010 at 5:18)*

**Policy stall?**

The thrust of Australia’s mental health strategy and the direction of cross-jurisdictional mental health initiatives, suggests that de-institutionalisation remains the policy of all levels of Australian governments. But progress towards completion of the implementation of that policy, by continued development and enlargement of the community sector, appears, largely, to have ceased.

A number of commentators have referred to a lack of commitment to spending on mental health as an important reason for the stalling of progress on the de-institutionalisation
agenda (Rosen, 2006). An oft-repeated statistic is that mental health services are required to address 13 per cent of the burden of disease in Australia with only 6 per cent of the health budget (McGorry, 2010). Rosen writes of his concern about this persistent under-funding:

There is a lingering concern however that although mental health reform in Australia has been heading broadly in an appropriate direction these reforms are already losing momentum; and core local mental health services are being eroded or have never adequately developed. Australia now lags behind similar Western countries in terms of government funding of mental health services... There is further concern that the closing of institutions in Australia has been half-hearted and incomplete; that it has not been accompanied by full transfer of real investment in mental health services and facilities; and that under-resourced services are again being expected to be everything to everyone.

(Rosen, 2006, p. 88)

Successful implementation of the policy of de-institutionalisation required simultaneous dismantling of an older mental health service system, the re-building of a new one and funding to achieve all of this. The more straitened public revenue climate, particularly in the 2000’s, has seen increased government appetite for the first part of that equation and a considerably reduced enthusiasm for the second. The unsatisfactory result is a much greater mismatch between demand and supply for services than prevailed at the initiation of the de-institutionalisation policy.

1.1.3 DISTRIBUTION OF FUNDING AND SERVICING RESPONSIBILITIES

Mental health service in Australia is funded, almost exclusively, by the public purse. In 2011-12, only 4.1 per cent (AUD$299 million) of total funding for the provision of mental health services nationally was provided by private health insurers with the balance of AUD$6.9 billion from state, territory and federal governments (Australian Institute of Health and Welfare, 2015, n.p.).

The possibilities for cohesive planning and delivery of services potentiated by this high level of public funding for mental health overall have not been realised. As Rosen (2013) suggests below, but also the National Mental Health Commission (National Mental Health Commission, 2014), politicisation and lack of commitment to genuine, strategic reform in the mental health sector is starkly apparent:
Australian Governments politicise their attempts at health service reform so much that they often turn out to be an unworkable mess or uncoordinated tangle of fragmented services, sometimes duplicating each other, and failing to plan or work together. This is as if Governments have “a reverse sausage machine” which starts with a well-formed sausage at one end, and produces a limp pile of mince at the other, leaving it to service providers on the ground to pick up the randomly spat-out bits and desperately fashion them into a vaguely useful system of care, which may provide some rough semblance of a service.

(Rosen, 2013, p. 234)

The cohesion of Australian mental health service system is grossly affected by the distribution of constitutional and fiscal powers as between state-level governments and the Commonwealth. The problem originates with the Commonwealth’s lack of power under the Australian Constitution to regulate the provision of health services (Griffith, 2006). This is reflected in the Australian system of mental health jurisdictions, with each Australian state and territory, but not the Commonwealth, having its own mental health legislation. The practical result is that most public mental health services programs are conceived and enacted by the eight principal state and territory governments. Despite this, state-level governments depend on the Commonwealth for the balance of funding towards a functioning national public health system, and are subject to the vagaries of the Commonwealth’s fiscal and other policy priorities (Wheelwright, 1995).

However, the constitutional restrictions on the Commonwealth have not proved entirely insuperable. Through the use of constitutional provisions such as the health and welfare power (Australian Constitution, section 51xxiiiA), the insurance power (section 51xiv), the grants power (section 96), the executive power (section 61) and the appropriations power (section 51ii), the Commonwealth government has involved itself more or less directly in support of particular types of mental health or health-related services. This involvement may come under more scrutiny, however, as the implications of the two Williams judgements of the High Court (Williams v. Commonwealth of Australia, 2012; Williams v. Commonwealth of Australia, 2014) play out. The judgement in the first of these cases effectively recalibrated the independent executive power of the Commonwealth, restricting its funding and contracting operations to areas in which there was statutory backing for Commonwealth involvement (Carney, 2013; Gerangelos, 2012). The second judgement reaffirmed constitutional boundaries for the making of such legislation. Future challenge to direct Commonwealth funding, operation or legislation in the mental health sphere might be expected if political advantage can be inferred (Griffith, 2014).
What are the distributed service responsibilities between levels of government?
The “reverse sausage machine” (Rosen, 2013, p. 234) comprised by this idiosyncratic
distribution of service and funding responsibilities has resulted in Commonwealth
government responsibility for funding ‘primary’ public mental health care, for providing
subsidies through Medicare for services by general practitioners, and for specialist mental
health and allied services for high-prevalence, low-severity mental health conditions such as
depression and anxiety disorders (Griffith, 2006). The Commonwealth provides subsidies,
also, for prescription medications under the Pharmaceutical Benefits Scheme and a limited
range of specific national programs such as e-health initiatives.

State and territory governments make a similar level of overall contributions but with
specific responsibility for provision of public mental health services for acute and chronic
serious mental illness (Australian Institute of Health and Welfare, 2014). The state-level
funding is distributed between state-run specialist mental health facilities including outpatient
services, and non-government community services, both principally servicing people with
serious mental illness.

The National Disability Insurance Scheme is a significant joint project with potential
for increasing the coordination of funding and services for Australians with chronic mental
illness in the future. The roll-out, commenced in 2012 and targeted for full implementation
nationally in 2018-2019, will be funded by the Commonwealth but with running costs from
2018-2019 shared approximately equally between the Commonwealth and the group of state-
level governments (National Disability Insurance Scheme, 2015).

What does the private sector provide?
There are a number of private citizens in Australia who pay for private health insurance with
cover for mental health conditions. Individuals and families also contribute by covering the
gap between the government subsidy and professional fee for privately-provided mental
health services. But private cover for people with pre-existing mental health conditions can
be very difficult to obtain and maintain (Judd, 2011). Only a very few can afford continuing
payment for non-subsidised, uninsured services.

Private insurers fund the provision of specialised mental health services in private
mental health facilities in Australia. Their overall usage, and the range of services provided
by them, though very minor compared with publicly funded services, has steadily increased
over the past two decades (Senate Select Committee on Mental Health, 2006). But there is
only limited collaboration between the private and public mental health systems, despite that
the number of specialised mental health beds in private hospitals represents fully 22 per cent of the total number of acute mental health care beds across the public and private hospital systems (Senate Select Committee on Mental Health, 2006, Chapter 12), and despite express policy intent to improve the relationship (Department of Health and Ageing, 2009). Patients who become subject to involuntary orders under mental health laws are mostly unable to take advantage of any private insurance they might hold to continue treatment with their private psychiatrist.

Effect of fragmentation on access to services

The particular distribution of power and responsibility for mental health servicing in Australia results in a highly fragmented service sector. The ‘system’ of service provision in the public sector is a many-headed hydra with little capacity to plan and implement strategies of integration that the policy of de-institutionalisation requires. The potential contribution of the private sector is poorly leveraged.

1.1.4 MEASURING ACCESS

To develop effective policy to address the mental health service access problem logically requires clarification of its scope. There is wicked complexity, however, surrounding the concepts of ‘need’, ‘demand’, and ‘access to’ and mental health services that renders illusive the measurement and definition of the access problem (Doran, 2013; Nous Group, 2014).

Problems in the definition and measurement of mental health need

The multi-dimensionality of the phenomena of access to health services has been recognised in health services and sociological literature for decades. Recent work suggests that the simple and obvious measure—the utilisation rate—is not reliable (Dixon-Woods, Cavers, et al., 2006; McIntyre, Thiede, & Birch, 2009). Alternative methods are confounded by an ongoing dialectic, engaging the state, the medical profession and ordinary people, that constantly constructs and re-constructs “appropriate objects of medical attention” (Dixon-Woods, Cavers, et al., 2006, p. 45). Overall, Australians’ notion of ‘what a mental health problem is’ appears to be expanding (Doessel, Williams, & Nolan, 2008). Psychiatric diagnostic criteria are regularly amended to authorise new conditions and de-legitimise ‘outdated’ ones with significant, unforeseen public policy effect (Frances & Widiger, 2012). There are definitional issues in distinguishing developmental disorders such as ADHD and
autism; personality disorders; mental disabilities such as acquired brain injury and intellectual disability; dementia, and mental illnesses. Mental illnesses are clinically defined in the two diagnostic manuals, the International Classification of Diseases (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (Ticehurst, 2001). Legally, however, they are described differently in every jurisdiction’s mental health law, and often in functional terms capable of encompassing many conditions other than mental illness as currently clinically defined (Shea, 1999)—including the binge-drinker’s hangover (Chappell, 2007)! It is not surprising, then, that the greater community—including its public safety, correctional and welfare services—often confuses and misunderstands these conditions of very different nature and origin (Intellectual Disability Rights Service, 2015).

Definition, measurement and the siloing of responsibility becomes more difficult because many people with a mental illness have a co-existent, non-mental illness condition that generates an additional, and yet entangled, need for quite different clinical or support services (V. A. Morgan, Leonard, Bourke, & Jablensky, 2008). These ‘co-morbidities’ and ‘dual diagnoses’ may involve a mental illness, a mental disorder, a physical or mental disability, a physical illness, or a substance abuse problem. Consumers with co-morbidities and dual diagnoses consume public mental health resources at a higher level than other consumers with mental illness, and incur more cost in the community and in their care, with the ‘revolving door’ syndrome of frequent re-hospitalisations often applying (Social Inclusion Unit, 2006).

A broader notion of ‘mental health’ is germane then to the development of relevant and effective policy but points again to the problem of scoping and measuring ‘mental health need’.

**Prioritising need in times of austerity**

Austerity politics highlight the problem of defining and quantifying mental health need. It is now understood in the public domain that the context of scarce resources, for public health measures generally but perhaps for mental health services particularly, is current and likely to continue, requiring forced prioritisation of different types of mental health need and demand (Lourey et al., 2012; Senate Finance and Administration References Committee, 2010).

There appears to be little consensus, however, about the appropriate resources to be devoted respectively to services responding to low-prevalence, ‘serious mental illness’ (such as schizophrenia); to high-prevalence anxiety and depression; to hospital versus community
facilities, and to people with ‘complex needs’ (Harrison, 2000). There is tension, also, in prioritising provision for each of the age-groups and stages of a mental health problem (from prevention through to early intervention and recovery) (Lane & Barbour, 2015; Rosen, 2006). Although advocates for specific areas regularly make their cases in the public domain, there has been no coordinated community debate about how the spending of scarce mental health funds should be prioritised.

Lack of accountability
There are models for accountability reporting by community-based providers that are onerous and unproductive (Ebrahim, 2003). On the other hand, some community providers in Australian mental health and disability sectors operate only too freely. As a consultant in one jurisdiction’s mental health sector between 2007 and 2010, I learnt that community-based providers of mental health support services may have no contractual or statutory quality-of-care obligations in relation to their publicly-funded clients. How can it be determined that such funded service is efficacious? The courts, too, have been reluctant to imply a service standard even for public clinical care providers (Bell, 2005). In the absence of satisfactory and standardised outcome measurement, large-scale waste of public mental health funds is virtually assured (Brown & Pirkis, 2009).

Mapping concepts of need, demand, services and evidence-based treatment
There is evidence that Australian policies of mental health service provision are not driven by disease prevalence, need or by any rational process of prioritisation, but are rather more influenced by demand features (political pressure achieves funding and de-funding); supply features (if we build it, they will come…) and location (city v. rural) (R. Williams & Doessel, 2008). The concepts of mental health need, demand, services-as-provided, and the delivery of effective treatment do not map directly over one another. They overlap rather than overlay, as depicted in Figure 1.
Figure 1
Relationship between mental health need, and supply of and demand for mental health services.

The system is sub-optimum to the extent that the zones of need, want, service and evidence-based treatment are not superposed. This mismatch of need and funding suggests significant systemic waste and inefficient usage of scarce public mental health funds. The resulting types of service inefficiencies are summarised in paragraphs A to C below.

A. Services not needed but provided:
‘Structural imbalance’ in the Australian mental health sector sees the ‘worried well’ in the community take up large volumes of service capacity (Doessel et al., 2008). Referring specifically to the then-new Medical Benefits Schedule items for psychologists’ services in 2006, Crosbie and Rosenberg (2007) identified that utilisation of those services, targeted for depression and anxiety, did not match the established epidemiology of those disorders. In particular, they noted high rates of demand and usage by middle-aged women, when studies show that young men have the highest risk of suicide, and that most mental disorders appear before the age of 25 (Crosbie & Rosenberg, 2007).

‘Not-needed’ services also include psychopharmacology treatments with spurious
therapeutic value and iatrogenic side-effects (Bracken et al., 2012), and ineffective, repeated involuntary hospitalisations (Kisely & Campbell, 2007a; Morris, 2006; Wales & Hiday, 2006).

B. Services needed and not provided:
The second phenomenon in the “structural imbalance” (Doessel et al., 2008) of the Australian mental health system is the large volume and range of unmet mental health need (Hosie et al., 2014).

Such need may not necessarily be demanded. There is a recognised problem in Australia, in particular geographic and demographic sub-populations (e.g. rural males, youth, older adults, and culturally and linguistically diverse populations), of an unwillingness to seek help, or even to hide the presence of a mental health condition (Choi et al., 2012). There are few services that seek out the engagement of such needy potential consumers (Walker & Reibel, 2013).

But ‘needed and not-provided’ service types are many. They include the inadequate provision of assertive community-based treatment (including by compulsory order) (Dietzen & Bond, 1993; Kisely & Campbell, 2007b), and the provision of timely, appropriate, effective, assertive treatment (Wales & Hiday, 2006) more generally.

C. Services provided with and without evidence of efficacy:

Even if funding is directed to an established mental health need, there is the further variable of the effectiveness of the service provided. Doessel et al (2008) allude to a significant problem in the use of funding for non-evidence-based therapy, citing studies showing that many Australian clinical service providers are not faithful to evidence-based treatment protocols, with the result that the mental health of patients is often not improved by the treatment provided.

There is waste here, also, in terms of the opportunity cost of the better use of the non-efficacious funding dollars.

In a world where the health dollar is finite, it is essential to ask whether …mental health spending…has given us a comparable return on investment, measured in terms of increased quantity and quality. The reality is we do not know and this, in our view, is a critical problem. Unlike other areas of health care, little attention has been given to ensuring efficiency in public sector mental health service delivery. Achieving value for money remains one of the key issues to be tackled in our national mental health reform.

(Whiteford & Buckingham, 2005, p. 400)
‘No-evidence’ waste arises not only from the failure to apply clinical protocols, but also from embedded inefficiency, lack of knowledge about how to apply funds effectively, and from changes to effective programs induced by austerity politics. For example, it has been argued that the psychological services program ‘Better Access’, designed for diagnosed high-prevalence disorders such as depression and anxiety, ceased to be an effective form of treatment in 2013, when Budget cuts reduced the number of professional visits attracting Commonwealth subsidy (Littlefield, 2014).

Conclusion
Setting optimum policy for the problem of access to mental health services in Australia requires factoring of epidemiological prevalence, changing diagnoses and treatment protocols, public demand, lack of engagement by needy, ‘should-be’ consumers, actual service utilisation, cost, co-morbidity, the clinical evidence base, and the normative considerations of the various stakeholders. This is a policy task of considerable complexity.

The relatively recent Sax Institute report, reported that the “evidence base is insufficient to guide policy decisions” (Doran, 2013, p. 7). Certainly, it appears that simplistic demand, supply and service utilisation measurements provide inadequate and inaccurate representations of the policy problem of access to mental health services overall. Not only does demand not equate with the supply of services, but demand does not equate with need for service, availability of service nor with the proven effectiveness of service. This presents additional practical and political challenges to policymakers with limited funds to spend and no clear direction for prioritisation.
1.2 A DEFINITION OF ACCESS FOR THIS THESIS

This Introduction has identified the multi-dimensional complexity of the notion of mental health access in Australia, spanning considerations of need, demand, provision, efficacy and norms. It is necessary, however, to select a definition for access to apply in this thesis.

Access to what?
Facilitation of access to voluntary treatment is a significant and viable object for possible address in mental health law (McSherry, 2010). Nevertheless, the machinery of the current model of mental health law in Western jurisdictions is directed, overwhelmingly, to the provision of involuntary treatment. It is necessary to consider, then, whether compelled receipt of mental health service is ‘access’ to that service for the purposes of this thesis.

Dictionary definitions of ‘access’ don’t entirely exclude the notion of compulsion to enter, obtain or make use of a thing, and yet full definitions of the concept feature expressions of freedom (‘permission’, ‘liberty’, ‘right to’, or ‘ability’) rather than compulsion (“Access”, 2015). Explorations of the notion of access to health service in academic literature, also, point toward individual freedoms and personal agency.¹ By contrast, neither in common nor in academic usage are convicted criminals provided with ‘access’ to ‘prison services’. ‘Access’, in both common and academic health usage, refers to entrance to or a pathway towards a desired option rather than a non-negotiable gateway to undesired treatment and detention.

It is inescapable that involuntary treatment is the form of ‘access’ currently facilitated by Australian mental health law.² For the purposes of this thesis, then, the definition of ‘access’ will be deemed to include ‘compelled service receipt’.

But this unusual formulation of the notion of access will retain at least a measure of consistency with the positive tenor of the access word in common and in health service usage. As used in this thesis, the word ‘access’ will imply, at least, some benefit. The benefit will not be for the safety of the community or for medico-legal protection of the clinician nor for the political purposes of the state but, rather, for the consumer’s mental health. Thus, in results, findings, syntheses and conclusions forming part of this thesis, the

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¹ For example, the conceptualisation of ‘candidacy’ as described by Dixon-Woods (2006) and ‘empowerment of an individual to use’ (McIntyre et al., 2009).
² For more detailed discussion on this point, refer to sub-section 4.2.1.1 ‘Prioritise risk’ discourse supra.
word ‘access’ will refer to the use of a gateway to timely, appropriate and effective treatment, whether or not that treatment is compelled.

But access for who?
In this thesis, I will not attempt to describe yet another approach to conceptualisation of mental health need. Instead, I refer to access (as defined in this section) for people who:

- are covered by the definitions of mental illness (and the definitions of mental disorder and ‘dysfunction’ that apply in some jurisdictions) contained in Australian mental health law; and
- have treatable conditions.

There are differences in the populations covered by legal definitions of mental illness in the respective jurisdictions. What matters for the purposes of this thesis, however, are the effects of the law on access to service for the population of consumers purported to be served by the legislation—not on any more totalised, fictional, and, as demonstrated in this Introduction, largely unfathomable, demographic purporting to represent mental health need. Whether that population, as defined, appropriately reflects the needs and priorities of the community is an interesting and pertinent policy question deserving of further specific investigation.
1.3 THE ROLE OF MENTAL HEALTH LAW

This Introduction has, so far, described the policy problem of access to mental health services, and an argument for fundamental service system re-design to appropriately address it. The next section of this thesis will demonstrate why it is necessary, additionally, to re-consider the principal formal regulatory technology within the sector, mental health law. I will profile particular characterisations, within the literature, of the effect of risk-based mental health law on facilitation of access, and orient the rationale for this thesis in relation to those arguments.

Mental health law underpins mental health service

It is recognised that the mental health service system operates continuously ‘in the shadow’ of mental health law, and often subject to its organising influence (McSherry, 2008; C. Scott & Brown, 2010). Bernadette McSherry describes mental health law as “paramount for the functioning of the mental health system” (McSherry, 2008, p. 777). Unsworth describes it as the bones, brain and engine room of the service system:

[L]aw actually constitutes the mental health system, in the sense that it authoritatively constructs, empowers, and regulates the relationship between the agents who perform mental health functions.

(Unsworth, 1987, p. 5)

Concern about the relationship between mental health law as a systemic underpinning, and the outcome of access to the service system, is not a novel pre-occupation. Over two decades ago, John Petrila warned that focus on patients’ civil rights in mental health law reform had resulted in neglect of the “crucial policy issue of how to organise and pay for accessible…services and supports” (Petrila, 1992, p. 90).

Focus in the academic and policy literature on the structural agency of mental health law in the facilitation of access has arisen on two fronts. Both will be outlined briefly in the balance of this sub-section. The first, and most recent, is human rights-based and reform-oriented, seeking representation of the ‘right to health’ in new versions of mental health legislation. In the second debate, focussed on existing mental health laws, facilitation of access is leveraged as the principal answer to the several planks of criticism of the ubiquitous risk-of-harm legal criteria for involuntary detention and treatment.
Mental health law reform to support the right to health

In recent years, rights-based approaches in the literature have sought pragmatic form for expression of a positive right to mental health service, both in mental health service provision and the law (Carney, 2010; Carney, Tait, Perry, Vernon, & Beaupert, 2011; Freckelton, 2009; McSherry, 2008, 2010; McSherry & Freckelton, 2014). Prominent Australian mental health law academics Terry Carney (2010), Bernadette McSherry (2008a, 2010, 2014) and Ian Freckelton (Freckelton, 2009; McSherry & Freckelton, 2014) have explicitly identified the direction as a new focus for mental health law reform. This represents a shift, in the academy at least, from the previous focus on ‘negative rights’ (for example, to safeguard consumers’ autonomy and bodily integrity) towards the reflection of ‘positive rights’ to services and support (Bartlett, 2010; Donnelly, 2008).

This shift in focus reflects developments in human rights law, in particular of the Australian adoption of the Convention on the Rights of Persons with Disabilities in 2006 (Donnelly, 2008; McSherry, 2008; Minkowitz, 2007; Weller, 2009), and the rise of the nascent, cross-disciplinary field of therapeutic jurisprudence (Freckelton & McGregor, 2010). It has also arisen across an era, socio-politically, in which public mental health treatment has shifted from being regarded as an unfortunate though necessary tool to control a difficult sub-class (Lincoln, 2006), to a desired scarce resource for which consumers of all backgrounds must compete.

The ‘risk-of-harm’ model in Australian mental health law

To intelligibly describe the second debate, featuring facilitation of access as the trump argument against clinical, ethical and rights-based concerns about risk-based mental health law, it is necessary to provide some detail about the framework of that model.

In Australia, mental health legislation is made by each state and territory government. The respective laws are:

- *Mental Health Act 2007* (New South Wales);
- *Mental Health Act 2014* (Victoria);
- *Mental Health Act 2013* (Tasmania);
- *Mental Health Act 2009* (South Australia);
- *Mental Health (Treatment and Care) Act 1994* (Australian Capital Territory);
- *Mental Health Act 2014* (Western Australia); and
- *Mental Health and Related Services Act* (Northern Territory).
Mental health law is strikingly similar in its basic content as between the Australian jurisdictions and internationally. The law in each jurisdiction expresses a range of objectives, but nearly always includes a version of the following three (Hale, 2007):

- to protect the rights of people with mental health conditions;
- to protect society (from harm caused by people with mental health conditions), and
- to facilitate access to treatment.³

Fundamentally, mental health laws establish legal authority, administrative process and describe rights surrounding the involuntary assessment, treatment and detention of people with defined mental health conditions. In the vast majority of jurisdictions in the United Kingdom, the United States, Canada and Europe, the criteria for activating these compulsory measures in relation to a particular person includes a measure of the risk-of-harm that the person may cause, and often also, of the seriousness of that harm (Large & Nielsen, 2008). All Australian jurisdictions feature risk-of-harm criteria as necessary conditions for involuntary treatment. Various expressed, these criteria are summarised in Table 1:

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3. See Table 8 at sub-section 4.2.1.1 ‘Prioritise risk’ discourse for further detail and discussion about the express objectives of Australian mental health law.
<table>
<thead>
<tr>
<th>Table 1</th>
<th>Dangerousness criteria as expressed in Australian mental health laws.</th>
</tr>
</thead>
</table>
| **Mental Health (Treatment and Care) Act 1994** (Australian Capital Territory) | e.g. section 28:  
(b) the [tribunal] has reasonable grounds for believing that, because of the illness, the person is likely to—  
(i) do serious harm to himself, herself or someone else; |
| **Mental Health Act 2009** (South Australia) | e.g. sub-section 21(1):  
(a) the person has a mental illness; and  
(b) because of the mental illness, the person requires treatment for the person’s own protection from harm (including harm involved in the continuation or deterioration of the person’s condition) or for the protection of others from harm; |
| **Mental Health Act 2007** (New South Wales) | e.g. section 14:  
A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:  
(a) for the person’s own protection from serious harm, or  
(b) for the protection of others from serious harm. |
| **Mental Health Act 2013** (Victoria) | Section 5:  
(b) because the person has mental illness, the person needs immediate treatment to prevent—  
(i) serious deterioration in the person’s mental or physical health; or  
(ii) serious harm to the person or to another person; |
| **Mental Health Act 2014** (Tasmania) | e.g. section 40:  
(b) without treatment, the mental illness will, or is likely to, seriously harm—  
(i) the person’s health or safety; or  
(ii) the safety of other persons; |
| **Mental Health and Related Services Act, 2004** (Northern Territory) | Section 14:  
(ii) the person—  
(A) is likely to cause imminent harm to himself or herself, a particular person or any other person; |
| **Mental Health Act 2014** (Western Australia) | Section 25:  
(b) that, because of the mental illness, there is—  
(i) a significant risk to the health or safety of the person or to the safety of another person; or  
(ii) a significant risk of serious harm to the person or to another person; |

Each law also includes a range of additional criteria for involuntary treatment which differ between the jurisdictions but concur in some common themes (such as that necessary...
treatment could not be provided in a ‘less restrictive environment’, an additional criterion in all Australian mental health laws).

**The origins of risk-based mental health law**

The current risk-based model of mental health law dates from the 1970s. It was during this decade that the criteria for involuntary admission shifted to the legally-oriented risk-of-harm or dangerousness criteria, from the earlier, medical, need-based criteria. The change originated in the US in the context of consumer rights-based concerns about excessive psychiatric paternalism, illustrated by celebrated coverage of specific examples of poor institutional conditions and treatment over-reach (Petrila, 1992).

Risk-based mental health law sought to ensure that psychiatrists could not infringe the human, and common law, rights of their vulnerable patients by such intrusive interventions as involuntary treatment and detention, except in the most serious of circumstances. It was a rationale for mental health law focussed on fairly keeping people out of a mental health system at a time when it was better-resourced.

A more demanding issue for the mental health system in contemporary times is about fairly getting consumers in to a relatively under-resourced system (Freckelton, 2009). The relevance of the older, risk-based form of mental health law to this much newer problem of access to service is precisely the concern of this thesis.

**Rights-based and ethical criticisms of risk-based mental health law**

There has been criticism of risk-based mental health law since its earliest iterations that it is unethical, discriminatory and inconsistent with human rights. From an ethical perspective, psychiatric clinicians, since the instigation of the model, have been concerned that the risk-of-harm criteria closes-off their attendance upon needy patients who would benefit from treatment but would not likely commit acts causing harm (Bagby, Thompson, Dickens, & Nohara, 1991; Community Health and Services Complaints Commissioner, 2002; McCready & Merskey, 1981).

Clinicians have also been concerned about the ethics of preventive treatment and detention, being treatment and detention to prevent harm that the patient has not, and only may (or may not) commit, arguing that treatment under such conditions re-purposes practice away from therapy, and towards policing and social control (Pols, 2005; Rosenman, 1998; Schaler, 2012; Szasz, 1974).
An allied argument identifies a rights conflict implicit in the one regulatory instrument seeking to protect both the community’s and consumers’ rights—particularly in the context of a consumer’s coercive treatment and detention ostensibly to prevent harm to others (Allen & Smith, 2001; Fistein, 2011).

On human rights grounds, there has been significant protest, in the last two decades particularly, about the application of risk-based, preventive involuntary treatment and detention of patients who have mental illness but who retain their mental capacity to consent to or refuse treatment. It is argued that involuntary treatment provided on a risk-of-harm basis to capacitous mental health consumers is discriminatory, when the personal autonomy of capacitous non-mental health patients to make even highly questionable decisions about their own health is valourised and protected by the common law (Allen, 2005; Dawson & Szmukler, 2006; Donnelly, 2008; Large, Niellsen, Ryan, & Hayes, 2008; Richardson, 2007; Szmukler, Dawson, & Daw, 2010). Nor does preventive involuntary detention on the basis of risk apply to other groups of citizens, such as some substance-abusers and perpetrators of domestic violence who, unlike the vast majority of mental health consumers under involuntary orders, have previously committed, and are even considered likely to commit further, substantial harm either to themselves or to others (Szmukler, 2003).

It has been argued further that risk-based mental health law encourages the public stereotype of the ‘dangerous person with mental illness’, perpetuating the crippling stigma (Szmukler et al., 2010), and delaying the initial treatment of schizophrenia (Large et al., 2008).

Clinical concerns with the efficacy of risk-of-harm technology
More relevant to the rights-neutral, regulatory governance approach adopted in this thesis is another strong stream of protest to the effect that the risk criteria simply do not ‘work’. Commenced by leading academic and psychiatrist George Szmukler in the early 2000’s, this stream of literature argues that, because the base rate of violence in the relevant population of consumers is so low, and the range of contingency so wide, the risk assessment technology and processes used by psychiatric clinicians to assess risk-of-harm can never be better than vastly inaccurate (Hayes, Niellsen, Sullivan, Large, & Bayliff, 2007; Large, Ryan, Callaghan, Paton, & Singh, 2014; Owen et al., 2009; Szmukler, 2001b, paras. 26 and 28; 2003; Szmukler et al., 2010; Szmukler & Rose, 2013). Furthermore, it has been demonstrated that anti-therapeutic outcomes afflict each of the four population sub-groups of risk-assessed consumers in the matrix of true-false and high-low risk (Large, Ryan, Singh, Paton, & Niellsen, 2011).
To be clear, none of these arguments dispute the value of compulsory treatment or detention in appropriate circumstances. Rather they dispute that the basis for application of such a significantly intrusive regulatory intervention should be the speculative and anti-therapeutic criterion of risk-of-harm. Instead, most anti-risk proponents suggest the principal criterion for involuntary processes should be whether the consumer possesses mental capacity to make their own health decisions (Szmukler et al., 2010; Large, Ryan, Singh, Paton, & Nielssen, 2010).

Facilitation of access employed as a trump card

In answer to the anti-risk proponents, contemporary supporters of risk-based law mostly acknowledged the inherent rights and ethical conflicts that are raised by risk-based mental health law, and yet claim for it a surmounting advantage. This is that, crucially, and in accordance with its express objectives, risk-based mental health law facilitates access to treatment. They argue that removal of the risk criteria would decrease the ‘catchment’ of the law, making it impossible for clinicians to use the law to protect and treat vulnerable, and potentially harmful, people who nevertheless retain decisional capacity (A. Buchanan, 2010; T. Burns, 2010; Donnelly, 2008). As Special Minister of State Rosie Winterton argued, when the House of Lords sought to expand the role of mental capacity within the UK’s Mental Health Act in 2007:

\[\text{Not all suicidal patients have impaired judgement. The Lords in effect are expanding the right to suicide. Examples psychiatrists have given to me are of a young women with borderline personality disorder who are suicidal but do not have impaired judgement. Who exactly are we helping by not enabling clinicians to help this woman?... Every restriction [by the Lords on the use of the risk criteria] is a patient untreated, a family in distress.}\]

\[(Winterton, 2007, paras. 26 and 28)\]

By contrast, and with direct reference to the usual troika of objectives in mental health law in which facilitating access to treatment is one, British legal academic and Deputy President of the Supreme Court of the UK, Baroness Hale of Richmond, asserts the reverse position on the effect of risk-based law on the facilitation of access, famously distilling its:

\[\text{4. At the time of writing, three Australian mental health jurisdictions—the ACT, Western Australia and Tasmania—include mental capacity alongside risk in their sets of mandatory criteria for compulsion.}\]
overlapping but often competing goals: protecting the public, obtaining access to the services people need and safeguarding user’s civil rights… [T]here is no doubt that the law finds it hardest to aim at obtaining access to services.

(Hale, 2007, p. 19)

**Fresh perspective needed on the workability of the risk-based law**

In summary, the literature encompasses diametrically opposed viewpoints on the effect of the current model of risk-based mental health law on facilitation of access: views that it facilitates, and views that it inhibits, access to treatment. There is evidence of the negative effect of the risk provisions clinically and systemically. There are arguments based in human rights and medical ethical discourse. There is no known socio-legal approach, however, that specifically addresses the effect of risk-based mental health law on one of its express objectives, access, from the perspective of mental health law as an instrument of regulatory policy.

If risk-based mental health law does not facilitate access to service—or worse, inhibits access—the rationale for the continuation of this highly intrusive regulatory intervention may be fatally discredited. For, further to it being discriminatory, non-ethical, stigmatising and technologically dysfunctional, risk-based mental health law will be shown to be a failing instrument of policy.

This section has described the relation of mental health law to the service system and described two streams of literature that problematise access to service in relation to the law: one rights-based and reform-oriented, and a second, addressing problems with the existing and prevailing model of risk-based law. This thesis, with its empirical focus, is located within the second debate.
1.4 FOCUS AND SIGNIFICANCE OF THE RESEARCH

Re-examine the system, re-examine its regulation

Poor mental health in the Australian community is already causing significant economic, social and personal cost. It has been shown that, in the context of the foreseeable major increase in demand for mental health, a business-as-usual approach to service provision—even with some policy or funding boosting—is no longer tenable.

The re-design of systems of public mental health service provision in Australia is currently under consideration (Dutton, 2014; Nous Group, 2014). It has been shown that mental health law is a fundamental structural element of that service system. As part of any overall system re-design or policy re-set, the purposes, strategy and, most importantly, the effect of the principal regulatory technology in the sector, mental health law, should be reviewed also.

Access is still a vital focus but is risk?

It is likely and appropriate that the problematisation of public mental health, in the current and coming socioeconomic times, will demand continuation of the current express objective of ‘facilitation of access to service’ within the law. As argued in the previous section, however, a substantial question has developed over whether or not the current risk focus of the law should also continue.

In the work of this thesis I am interested in whether or not mental health law ‘works’ in relation to one of its express objectives, the facilitation of access. Accordingly, the research question founding this thesis is: *what is the effect of the current risk-based model of Australian mental health law on its express objective to ‘facilitate access’ to mental health service.*

In relation to the definition of access to be pursued in the course of this investigation, I refer to section 1.2 A definition of access for this thesis infra.
1.5 THEORY AND METHODOLOGICAL DEMANDS

1.5.1 CHOICE OF A REGULATORY GOVERNANCE APPROACH

Less normativity required!

This thesis investigates whether a regulatory instrument, a policy tool, in the form of the current model of risk-based mental health law, is successful in achieving one of its express objectives. In contrast to the concerns of rights-based scholars, medical ethicists and mental health sector advocates who also address issues around risk-based mental health law and access, this is a relatively non-normative quest. The theoretical framework for investigation, therefore, should be capable of supporting rigorous interrogation of the instrumentality of the law, unhampered by assumptions that a ‘social good’ is necessarily the true policy objective. The instrumental relation of risk-based mental health law, in practice, to a particular ostensible policy objective, access, is the context to be tested.

A critical criterion: capacity to factor plurality

The multi-dimensionality of the policy domain of mental health was highlighted in an earlier discussion at sub-section 1.1.4 Measuring access. There, this thesis described a lack of consonance in notions of need, service and demand—as perpetuated by the action, and inaction, of the state, mental health consumers and the medical profession, and by other important stakeholders in the sector such as carers, community-based service organisations and the balance of the community. ‘Access to service’ is of course a concern of a number of these groups, but there are clearly other, competing objectives in play—such as the community’s concern about being safe from harm (Angermeyer & Dietrich, 2005).

It might be expected that, as in other policy domains, the resident stakeholders within the mental health sector are not merely passive, but rather actively pursue strategies to further their objectives (Croley, 2000). Additionally, then, an empirical investigation into the effect of risk-based mental health law on access to service requires a theoretical framework with capacity to factor the complexity of a number of stakeholders, who have a number of objectives (including access), and employ a number of strategies and technologies (including mental health law) to achieve them.
In summary, the theoretical framework founding the methodology for investigation of the research question must possess scope for non-normative analysis of the action of regulatory instrumentation in a policy field with multiple stakeholders, multiple strategies of influence and competing objectives. In answer to this challenge, I have chosen for the work of this thesis to engage with a number of contemporary approaches to regulatory governance.

**Traditional and ‘new’ regulatory governance theory**

Focus in the study of governance and, more latterly, of regulation, has expanded from its original concern in the latter part of the 20th century, with the achievement of collective welfare goals such as public education and health, to focus on the dynamics of competing interests, when even regulatory policy itself becomes one of the outcomes negotiated in a field of societal relations (B. Morgan & Yeung, 2007).

Arising in the field of political science, the study of regulatory governance originally followed the economists in contrasting the free play of the market with regulatory interventions of the state (C. Scott, 2001). Traditional regulatory governance theories feature the state’s attempts to alter behaviour “according to defined standards or purposes in order to address a collective problem” (Black, 2008, p. 3) by employing policy instrumentation, the contents of a regulatory tool-kit, ‘re-stocked’ over time (Freiberg, 2010).

More contemporary theorists, however, embrace a sociological perspective, arguing for less distinction between the regulatory activity of markets, the state and of other influential organisations and individuals, and as between notions of ‘private’ and ‘public’ (C. Scott, 2004). Instead, these theorists consider ‘regulation’ to be any behaviour intended to “control, order or influence the behaviour of others” (Parker, Scott, Lacey, & Braithwaite, 2004, p. 1). The ‘new regulationists’ pluralist vision of regulatory governance in the devolved, neoliberal world encompasses not only a range of public and private actors attempting to influence outcomes, but a range of regulatory processes and strategies, exercised by them and upon each other (Burris et al., 2010). The result is a vibrant field of study that is interested in both the intended and unintended effects of a variety of forms of regulatory behaviour (Parker et al., 2004).

**A taxonomy of ‘new regulationist’ approaches**

Wright and Head (2009) have catalogued the array of new regulationist approaches into three groups of divergent, theoretical approaches. Under *normative* approaches, they include Ayres’ and Braithwaite’s (1992) ‘responsive regulation’ theory, which seeks to improve effectiveness of regulatory action in the achievement of social goods by better calibrating
regulatory impetus and desired compliance modes. *Descriptive* approaches include the ‘smart regulation’ approach (Gunningham, Grabosky, & Sinclair, 1998), in which a set of design principles is deployed towards the development of a customised regulatory fabric that addresses not only the relevant public interest objectives, but equitable and political considerations as well. Lastly, and most relevantly for this thesis, Wright and Head distinguish a range of *pluralist* regulatory governance approaches for which they cite direct provenance from Manuel Castell’s network society conceptualisation (Castells, 2000; Wright & Head, 2009).

**Elements of network-inspired regulatory governance theory**

Scott (2004) summarises the central concerns of the pluralist governance approach: first, that the state is not necessarily central to the process of regulation; secondly, that the state’s formal laws may not, and other of society’s informal processes of ordering may, instead, be determinative of outcomes; and last, that state law can only be determinative when working cohesively with relevant, informal processes of ordering. Concomitant with the de-centredness of the state, the notion of public interest in the pluralist approaches is less prominent, although the policy domain overall demonstrates a form of self-sustaining logic, as Castells points out below:

> Networks, as social forms, are value-free or neutral. They can equally kill or kiss: nothing personal. They process the goals they are programmed to perform. All goals contradictory to the programmed goals will be fought off by the network components. In this sense, a network is an automaton. But, who programmes the network? Who decides the rules that the automaton will follow? Social actors, naturally. Thus, there is a social struggle to assign goals to the network. But once the network is programmed, it imposes its logic to all its members (actors). Actors will have to play their strategies within the rules of the network.

*(Castells, 2000, p. 16)*

**What is, and what happens in, ‘regulatory space’?**

The work of the pluralist regulatory scholars encourages appreciation of the policy domain as social system containing private and public agencies, organisations, professions, groups, and potentially even individuals, each establishing strategic relations with one another, and to the collective as a whole (Burris, Drahos, & Shearing; Hancher & Moran, 1989). Thus, the dynamism of regulation can be conceived as diffused across a ‘regulatory space’ populated by a network of stakeholders, including the state (Hancher & Moran, 1989; C. Scott & Brown, 2010).
Within this space, each of the stakeholders implements a range of strategies designed to shape the others’ behaviour in the direction of its interests. These strategies may involve the use of such technological means as formal law, the so-called ‘soft-law’ strategies (such as industry guidelines and performance appraisal), and non-law strategies such as self-regulation and the casting of blame. These technologies are employed as forms of regulation. The strategic expressions of influence emitted by each stakeholder are likely to be more or less successful depending on the stakeholder’s relative regulatory ‘capacities’ (C. Scott & Brown, 2010).

**Synergy between network governance and the demands of the research question**

It is within this group of pluralist regulatory approaches that the search for a theoretical framework for this thesis finds rest. Network-inspired regulatory theory can not only cope with pluralism in objectives in the mental health sector, in the number of relevant stakeholders, and with the plethora of strategies and technologies employed, it is specifically oriented to analysis of just such complexity. Similarly, as the state takes its place in the network governance view of the world as ‘just another stakeholder’ with its own motivations, capacities and weaknesses, normative assumptions about the effect of a particular regulatory technology, such as the law, or about its agenda, are not only avoided but become legitimate focii for scholarly enquiry.

Furthermore, a network governance approach has potential to identify the range of stakeholders, their respective agenda and capacities to prosecute those agenda, and to generate hypotheses, about the suite of technologies in play. Thus, the relative salience of the access objective, and place of mental health law within the raft of other operative technologies within the complex social domain that is the mental health sector, might be gauged.

### 1.5.2 GOVERNMENTALITY

Despite all of its synergies, however, network governance does not answer the brief of the research question for this thesis in its entirety. For, as noted in section 1.4 Focus and significance of the research infra, the research question for this thesis features the effect of risk-based mental health law *in practice*. We are interested in what the law does. This suggests a more empirical approach than the theory-driven regulatory governance
approaches arguably encourage. Fortunately, there is a complementary theoretical direction. We find this in the concept of ‘governmentality’ (C. Scott, 2004; Wright & Head, 2009).

**What is governmentality?**

The conceptualisation of governmentality addresses the relationship between power and knowledge. It is an approach to the ‘mentalities of rule’—that is, to the experience, rationalities and forms of subject creation associated with governing and being governed (Miller & Rose, 2008).

**The development of governmentality**

Governmentality was first identified by the philosopher Michel Foucault, as he traced the development of power relations in the West in a lecture at the College de France, in 1977. But the notion of governmentality has evolved significantly since its original outing. There was some development by Foucault himself before his death in 1984. There has been much more since, however, in the writings of a range of scholars, including Nikolas Rose and Mitchell Dean, who have applied the conceptualisation to sociological and political concerns with neoliberalism. At the time of Foucault’s death such issues were only just beginning to emerge (Rose, O’Malley, & Valverde, 2006). Even more recently, governmentality has been applied with more empirical emphasis, in social policy analysis (Marston & McDonald, 2006), and in a ‘realist’ mode, a form of “ethnography of government” (McKee, 2011b).

**Complementarity with the pluralist regulatory governance approaches**

Governmentality is closely allied with the network governance project. Its principal concern, Foucault would say, is to deconstruct ‘the conduct of conduct’, which, in practice, is analogous to the network governance scholar’s task to analyse regulatory practice. Like the regulatory governance approaches, governmentality is interested in “the whole range of practices that constitute, define, organize and instrumentalise the strategies that individuals…use in dealing with each other” (Foucault, 2003a, p. 41).

These can be understood as:

…strategic games between liberties—in which some try to control the conduct of others, who in turn try to avoid allowing their conduct to be controlled or try to control the conduct of the others—and the states of domination that people ordinarily call “power.” And between the two, between games of power and states of domination, you have technologies of government.

*(Foucault, 2003a, p. 40)*
The synergy of governmentality with regulatory governance approaches, despite their disparate disciplinary origins, has been recognised by a number of writers. These include Wright and Head (2009) who credit Foucault, along with Castells, with the origins of the pluralist regulatory governance approaches, each with their similar ‘post-’ preoccupations with fragmentation, complexity, and distributed relations of power.

Utility of a governmentality approach for the instant research
The stream of contemporary governmentality scholarship known as ‘realist governmentality’ has particular relevance to the requirements of the research question for this thesis in that, unlike the more discursive post-Foucauldian directions of Rose and Dean, it is oriented to empirical, 'street-level' investigation (McKee, 2009). It is with this characteristic that I intend to backstop the empirical shortfall of the network governance approach. Realist governmentality will assist in identifying effects resonating in access, and the different forms of practice of mental health law.

1.5.3 NETWORK GOVERNANCE+GOVERNMENTALITY: APPLYING AN INTEGRATED MODEL

Both network governance and governmentality approaches are incorporated in this thesis in a mixed-model methodology which is developed and described in detail in Chapter 2 of this thesis.

Four phases in a mixed-model methodology
The primary methodology for the study encompasses four phases:

- **Phase I: Scoping** requires an initial approach to the central problematisation of the research question and an hypothesis of the composition of the relevant policy domain.

- The **Phase II Network Governance sub-study** describes a qualitative, literature-based study, based on a method for ‘critical interpretive synthesis’ developed by Mary Dixon-Woods (2009).

- The **Phase III Governmentality** sub-study adopts an ‘ethnography of government’ (McKee, 2011a) approach founded in a realist governmentality theoretical base.

- **Phase IV Synthesis** is a formal process for the synthesis of the two sub-studies, derived from the larger synthesis principles of meta-study (B. L. Paterson, Canam,
Jillings, & Thorne, 2001), meta-narrative review (Greenhalgh, Potts, Wong, Bark, & Swinglehurst, 2009) and meta-ethnography (Noblit & Hare, 1988).

Limitations
The established field methods engaged for the purposes of this thesis have been adapted for the time and cost limitations of my PhD candidacy. These modifications will be addressed in detail in Chapter 2.

The mixed-model framework is ‘fit for purpose’
The mixed-model framework particularly suits analysis of the multi-dimensional mental health policy domain, balancing discursive and empirical—and macro- and micro—forms of analysis. It will deliver normatively-neutral and politically-rich perspectives on the effect of the regulatory technology of risk-based mental health law on the regulatory objective, access to service.

Applicability in other social policy analysis contexts
The methodology specified in this thesis is designed with a view to the requirements of the mental health law and access research question. It is applicable, however, to other complex social policy analysis projects where a political, rather than a normative, approach to the objectives of government, and twinned macro-discourse and micro-practice perspectives, would be useful features for investigation of the policy problem to hand.

1.5.4 RECONCILING THE USE OF DISPARATE APPROACHES

It is acknowledged that the prosecution of the aims of this thesis requires success in the integration of approaches—network governance and governmentality—that have dissimilar paradigmatic, epistemological and normative foundations.

This section broadly describes the distance between the two approaches, the pragmatism underlying their integration in the mixed-model study, the reflection of that pragmatism in the background the researcher, and its value in relation to the inherent ‘messiness’ of regulatory policy analysis.

What disparity?
As noted previously, the pluralist regulatory governance approaches are relatively non-normative, and ‘post-’ compared to other regulatory governance approaches. But like
Castells, who asserts the structural determinism of networks, network governance theorists remain positivist and normative in their fundamental orientation (David, 2010). Thus, the quest to discover objectively ‘good’, ‘better’, or to ‘fix’ existing policy practice, underlies all of regulatory governance theory, including the pluralist approaches.

By contrast, the Foucauldian origins of governmentality are post-structural and deconstructivist. The contemporary scholarly stream of realist governmentality thinking that is employed in this thesis, however, has evolved from the “desire to escape the excesses of post-structuralism” (McKee, 2009, p. 478) and interest in “the concrete art of governing” (McKee, 2011b, p. 3). Realist governmentality interprets social discourse, practice, interaction and effect in located contexts, and with a firmly critical perspective, whilst at the same time recognising ambiguities and highlighting evidence of instability and constitutional change (Hobson, 2010; Stenson, 2005, 2008).

So, notwithstanding that network governance is at the ‘fluffier’, post-structuralist end of the regulatory governance continuum, and realist governmentality not far from it at the ‘concrete’ end of the spectrum of governmentality thought, there is some work to be done to rationalise paradigmatic, normative and epistemological distance between the approaches.

**Summary of the rationalisation argument**

The rationalisation of the specific disparities of approaches proposed for integration in the work of this thesis is presented in detail at sub-section 2.3.2 Objections and answers supra. In summary, the rationalisation has three pillars: first, as noted above, that network governance and realist governmentality approaches are disparate but not distantly so; secondly, that the conflict is resolved in the particular form of integration envisaged in the methodology—that is, with the realist governmentality project a discrete phase within an overall regulatory governance project; and thirdly, that the entire project is directed with a pragmatic view to the value of multiple perspectives (Parker, 2007; Wright & Head, 2009).

**Adoption of the pragmatist paradigm**

While linked to a normative stance centred on social well-being, the pragmatic perspective adopted for this thesis maintains a sceptical distance from regulatory ‘recipes’, suspecting that classic or habitual models of regulation could be poor guides to current problems (Parker, 1999). Instead, pragmatism comprises a ‘spirit of self-correction’ and capacity to break-free from claims to certainty and truth, allowing that a variety of approaches can contribute to the understanding of, and response to, regulatory challenges (Parker, 1999; Wright & Head, 2009).
The paradigm of pragmatism adopted in the methodology reflects my own orientation. I came to PhD candidature after several years as a consultant to the mental health law review process in an Australian jurisdiction. During this time I began to appreciate the exquisite policy difficulties posed by the radical distance between different stakeholders’ views of ostensibly the same phenomenon, and also a critical stance, as I became aware of stark disparity between policy and practice.

I approach the challenge of twinning the different perspectives in the mixed-model framework with an intention to remain accountable by attempting to ensure methodological rigour within each carefully-delineated phase of the project, and by employing appropriate integration protocols. I nevertheless intend to make claims, subject to methodological limitations, and whilst acknowledging that what founds them will be interpreted, contingent impressions of ‘what is real’.

**The value of the pragmatic integration of different perspectives for policy analysis**

Regulatory policy-making and analysis will always be an imperfect process, a rationalisation formulated as conditions (like time, budget and available data) allow. Unable, within such conditions, to rationally aggregate the utility of policy options for each of its citizen subjects, policy analysts frequently engage with ‘evidence’ in some form of totalised experience (Finsterbusch & Motz, 1980). But there is ‘epistemological violence’ in such aggregation (R. Jones, Pykett, & Whitehead, 2011, p. 491):

> Related work has drawn attention to the effects that systems of government at an epistemological distance can have on understanding personal needs and cultural sensitivities... This concern with the often blunt and insensitive nature of liberal systems of government has new significance in an era of libertarian paternalism, when new strategies are being put in place to govern the collective...with only limited understanding on how these strategies may impact on different... subjects.

(R. Jones et al., 2011, p. 492)

It is my view, reflected in the composition of the research framework, that the antidote to ‘epistemological violence’ in policy data, and thus perhaps also to the high incidence of failed policy, is to integrate evidence of policy subjects’ experience into policy analysis. As Braithwaite has noted: “the key public policy nut to crack is the ordering of local knowledge” (J. Braithwaite, 2000, p. 235). I consider that there is outstanding value to be gained, in social policy practice, from the factoring of such localised, personal, subjective representations as it is practically feasible to gather, alongside the more macro, objective,
totalised evidence. This central value motivates the pragmatism of the integrated methodology designed in this thesis.

**The value of pragmatic integration for the research question**

The methodology involves synthesis of the available ‘objective’ data as well as ‘subjective’ representations of the theatre of power relations salient to a particular social problem, and actual, or proposed regulatory policy. The research orientation is relatively non-normative, with a critical approach to determining the ‘street value’ of the access objective, and the productive action, rather than the rhetoric, of mental health law.

It is intended that the mixed-model approach to interrogation of a policy problem developed in this thesis not be judged as a flimsy of loosely-associated or disparate concepts, but as an integrated framework of productive antagonisms. There is a genuine attempt here to demonstrate the appropriateness of dialectic between a governance and a governmentality approach, and also of the potential contribution of this engagement, not only for the research question to hand but for social policy analysis more generally.
1.5 Thesis Outline

The balance of this thesis describes the development, application, and the results of application of a ‘governance+governmentality’ methodology to research investigating the effect of risk-based, mental health law on access to mental health service in Australia.

In Chapter 2, the methodology of the four-phased mixed-model framework is developed and explained. It addresses, also, the rationalisation of particular issues arising in the integration of the governance and governmentality approaches, and describes the field methods employed in each of the four phases. It describes both the action and the outcomes of action undertaken in Phase I: Scoping.

Chapter 3 reports and discusses the results of the Phase II: Network governance sub-study.

Chapter 4 reports and discusses the results of the Phase III: Realist governmentality sub-study.

Chapter 5 reports and discusses the results of Phase IV: Synthesis.

Chapter 6 concludes the thesis, summarising the results of the project in relation to the research question, addressing the achievements and limitations of the research, and outlining policy implications.
1.6 CONCLUSION

This Introduction locates the work of this thesis at the intersection of the serious and growing problem of access to mental health services for Australians, and debate around the diminishing rationale for the long-standing model of risk-based mental health law.

Mental health servicing in crisis
The Introduction reviewed the literature relating to the complex problem of access to mental health services in Australia. It was identified that the failure of policy to facilitate the delivery of evidence-based mental health treatment to those who need it currently constitutes a massive economic, social and personal cost to the nation, a cost projected only to increase in the near future unless a substantially new, different and effective policy approach to the sector can be developed. This thesis is constituted with a view to contributing to this vitally important objective.

The fading utility of risk-based mental health law
The Introduction also outlined the federal distribution of mental health servicing responsibility and mental health law jurisdictions. It described the origins and current schema of the prevailing model of risk-based mental health law, and the continuing bio-ethical and rights-based concerns with it.

The relationship between mental health law and the policy problem of facilitating service access was explored, with identification of ‘facilitation of treatment’ as one of three principal express objectives of the risk-based mental health law model. The focus of the research was configured at this point—does risk-based mental health law ‘work’ to achieve its objective to facilitate access?

A working definition of access
In section 1.2, the notion of ‘access’ was defined, for the purposes of this thesis, as the facilitation of timely, appropriate and effective treatment, whether this is provided voluntarily or involuntarily.

Theoretical framework
Regulatory governance theory arises for this thesis as an appropriate theoretical framework because the focus for research is the effectiveness of policy and its regulatory instrumentation in achieving one of its declared purposes. The network governance approach was identified with particular potential to produce theory in relation to the relative capacity, agenda and
identity of stakeholders within the mental health policy domain.

The post-Foucauldian realist governmentality approach was selected, adjunctively, to focus the research gaze towards vital evidence of the street-level effect on access to service arising from the practice of mental health law.

The Introduction prefigured the application of a novel, four-phase mixed-model methodology, integrating a qualitative network governance sub-study and a qualitative realist governmentality sub-study.
**CHAPTER 2: METHODOLOGY**

*David Cummins:* I’m not sure that it’s Big Data versus ethnography, but rather we’ve found that they complement one another in indispensable ways.

*Ken Mihalyov:* Data can take you a long way, but when people are involved it’s not always the whole story. You need to understand and document the way things really work, especially the interactions between different processes. There’s very often a difference between what you expect to have happen and what’s actually happening when people are involved, and that’s very enlightening.

*Representatives of Xerox Corporation discuss how Xerox uses analytics, big data and ethnography to help government solve “Big Problems” (Kerschberg, 2012)*

**Overview**

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   2.4.1 The problematisation ..................................... 60
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The Introduction to this thesis foreshadowed the development of a mixed-model study with an overall regulatory governance perspective, within it integrating network governance and realist governmentality sub-studies. This chapter outlines the rationale for this choice. Both the primary underlying methodology and the field methods employed in the application of the mixed-model are described.
2.1 PLURALIST GOVERNANCE APPROACHES

2.1.1 A RANGE OF GOVERNANCE APPROACHES

The regulatory governance field is characterised by a menu of approaches, each with different emphases on the position of the state, the purpose of regulation, the process of development of regulatory policy, and the function of regulatory theory. Wright (2009) points out that no single approach is fit for all regulatory policy purposes, that pragmatism should guide the choice of perspective for a given policy problem. This pragmatism is employed in this section of the thesis, in which a selection of approaches is reviewed for potential application in the current mental health law and access research project.

‘Public interest’ approaches: towards the common good
Morgan and Yeung (2007) characterise the regulatory governance field as comprising three fundamental strands. The more traditional ‘public interest’ approaches assume that government acts for society’s collective benefit, and regulates to correct the operation of markets so as to distribute resources more efficiently (Posner, 1974). Contemporary, political versions of public interest theory extend the concept of the ‘common good’ to non-economic aims, such as support for human rights or for the environment (Sunstein, 1990).

‘Public choice’: private interests competing within the policy domain
By contrast, regulationists of the second strand, influenced by the microeconomic ‘public choice theory’, are sceptical about the notion of regulation for public benefit, assuming that regulatory policy is an outcome achieved from the cumulative total of interest group pressures, where the set of self-interested agents includes both government and private stakeholders in a sector (J. Buchanan, 1987). Public choice theory describes regulation as a zero-sum game, with individual actors, including the state, competing to further their respective interests, which includes the establishment of a particular regulatory operating environment.

Hybrid ‘new regulationist’ theories
There has been some suspicion about the purist versions of both public interest theory and public choice theory: the first criticised as “idealistic and uninformed” (Croley, 2000, p. 7), and the second, as a “dark and unlovely myth” (Farina, 2000, p. 111). Morgan and Yeung
describe the third strand as a hybrid comprising the positive features of the first two. These are the pluralist, ‘new (or post-) regulationist’ theories (B. Morgan & Yeung, 2007; C. Scott & Brown; Wright & Head, 2009). As outlined in the Introduction, these include ‘responsive regulation’ which seeks an effective way to govern in the common interest, to discover ‘what works’ (J. Braithwaite, 2000); the ‘smart regulation’ design principles of Neil Gunningham et al (1998); and the group of ‘network governance’ approaches, which are specifically oriented to identification of, and response to a multiplicity of norms, regulatory agents and regulatory strategies and technologies.

As argued in the Introduction, the capacity for relatively non-normative analysis within pluralist dimensions, as possessed by the ‘new regulationists’, is vitally important for analysis of the policy problem of risk-based mental health law and access. The methodology for the mental health law and access project will be developed within ‘new regulationist’ theory, with particular focus on the network approaches.

2.1.2 NETWORK GOVERNANCE APPROACHES

This thesis will, in future sections, use the generic term ‘network governance’ for what is, in fact, a group of similar, network-oriented regulatory approaches. Somewhat loosely described by Wright (2009) as post-structural regulatory approaches, this group includes: ‘meta-regulation’ (Parker et al., 2004), the kernel of the ‘network governance’ approach (C. Scott, 2001), and the concept of ‘nodal governance’ (Burris et al., 2005). Each of these derive from a ‘public choice’-type appreciation of determinative power within and across fragmented, multi-stakeholder policy domains. Relatively non-normative (as between the public choice and public interest positions), each of these approaches also recognise the plurality of objectives across the domain, and feature a broad definition of the notion of regulation. Each, however, has specific emphases. The particular conceptualisations identified as useful for the present research are described in further detail below.

Meta-regulation

Like the other pluralist, regulatory approaches, meta-regulation is applied to multi-stakeholder contexts where there are “different forms of regulation (whether tools of state law or non-law mechanisms) each regulating each other” (Parker et al., 2004, p. 3).
The particular focus in meta-regulation is the mediation of law as a regulatory vehicle by other non-law influences in operation across the regulatory space (C. Scott & Brown). Law cannot be considered unimportant, but it may be less determinative of outcomes than it is often assumed to be the case (Parker et al., 2004). This is in contrast to the approach taken in traditional socio-legal research, which addresses a single, causal chain of variables, moving from the appreciation of a policy issue to the effects of action taken in response to it, as described in Figure 2.

![Linear model of the effectiveness of law (adapted from Paterson, 1998, p. 456)](image)

Parker and colleagues, instead, describe a multi-directional field of influences, a web of regulatory impetuses (C. Scott & Brown, 2010). In meta-regulatory analysis, this web becomes amenable to mapping, with the pattern and direction of the various influences between the agents within the field identified and recorded. The notion of a multi-directional field of influence, as opposed to a more traditional, ‘top-down’ view of regulation, and also of the idea of mapping that field, is a useful model for the methodology of the present research.

**Nodal governance**

The Introduction to this thesis referred to the conceptualisation of a policy domain in terms of ‘regulatory space’ populated by agents who exercise influence over (who ‘regulate’) each other (Hancher & Moran, 1989). The nodal governance approach dissects this notion...
further, averring, not only that regulatory influence is dispersed—variably—across a regulatory space, but that capacity to exercise influence (Burris, 2004) is similarly distributed. 

This focus on the characteristics of the actors, rather than on their inter-relationship, distinguishes the approach known as ‘nodal governance’ (Burris et al., 2005). The notion of the stakeholder as a network node emphasises their respective interactive and transforming characters:

Nodes...take a variety of forms, from legislatures and government agencies through neighbourhood associations and other non-government organizations ('NGOs') to firms and gangs... To be a governing node as this theory defines it, a node must have some institutional form, even if temporary. It need not be a formally constituted or legally recognized entity, but it must have sufficient stability and structure to enable the mobilization of resources, mentalities and technologies over time. A street gang can be a node, as can a police station or even a particular shift at a firehouse.

(Burris et al., 2005, p. 36)

The nodal governance approach posits that a node can regulate other nodes by exercising its capacity to mobilise tools and strategies to influence them to act in a manner consistent with the influencing node’s interests (Burris et al., 2005).

The composition of nodal capacity to influence: the NATO heuristic

The composition of nodal capacity has been explored within the heuristic of the acronym NATO (Nodality, Authority, Treasure and Organisation) formulated originally by Hood and Margetts (2007) but modified by Scott and Brown (2010) to apply to a non-state-centrist model.

Nodality refers to the relative ‘connectedness’ of a regulating stakeholder within a network, its information-collecting behaviour and its ability to trade, share or capitalise information as regulatory currency so as to influence the behaviour of other actors.

Authority is about the capacity for enforcement of a stakeholder’s drive for regulatory influence.

Treasure refers to the stakeholder’s reserves of, and its capacity to accrue and to mobilise, ‘regulatory capital’—mostly financial, but perhaps also electoral power or other resources of value in the particular context.

Finally, Organisation addresses the institutional characteristics, such as the staffing or command structure that affect the capacity of the stakeholder to ‘make things happen’ (C. 46.
Scott and Brown (2010). For example, a different level of organisational capacity will be possessed by a loose association of mental health consumer groups as compared with a nationally recognised peak body.

**Application of NATO to the mental health law and access project**

The NATO model is an important contribution to the methodology for the current project, where the mental health policy domain incorporates stakeholders with different strengths and capacity to influence.

**The relevance of the culture and interests of a stakeholder**

The possession of regulatory capacity is not the beginning and the end of the influence of a stakeholder however. Regulatory capacity may remain like an a valuable mineral in the ground, unless the stakeholder-in-possession knows and cares that it is there, formulates a strategy for making it useful, and then digs it up to use or sell. The characteristics, culture, interests, values and strategy of a nodal actor determine the level and form of actualisation of regulatory capacity, and are thus important objects for empirical investigation (C. Scott, 2001).

Though Scott (2001, at p. 333) noted that “institutions of culture…play an important role in delimiting the range of possible actions which the interdependent actors may take”, these cultural aspects of the character of the individual regulatory actor have not been specifically explored in the network governance literature.

**Formulating ‘agenda identity’ for this thesis**

I consider that the intrinsic motivating drivers and other cultural characteristics of a stakeholder are important empirical elements for the present research, as it attempts to locate and value the objective ‘access to mental health service’ within the menu of interests pursued by particular stakeholders and in the domain overall. In the absence of an existing heuristic or conceptualisation in the relevant literature for this concept, in this thesis I will address the cultural character of a stakeholder and their interests and objectives within the notion of ‘agenda identity’. This novel conceptualisation will take a role as an additional feature of the network governance methodology applied in the work, alongside elements of nodal capacity addressed through the NATO heuristic.
2.2 GOVERNMENTALITY

2.2.1 FUNDAMENTAL THEMES

The conceptualisation of governmentality has developed considerably since appearing in the 1970s—in response to the changing ethos of socio-political life, and its application in different fields. This section of the thesis will examine the evolution of the more contemporary stream of realist governmentality and its applicability for the present research.

Kernels of governmentality

Fundamentally, governmentality enables us to recognise and understand the productive use of power within the constantly shifting landscape of ‘what is problematic’ (Rose & Miller, 1992), whilst transcending moral judgments, and re-configuring the notion of resistance (McKee, 2009, 2011b).

As for the pluralist regulatory governance approaches, the position of the state, in governmentality, is not central. Instead, it is recognised that a “governmentalised field is likely to be inhabited, in a governing sense, by the state and other groups” (Ferlie, McGivern, & Fitzgerald, 2012, p. 3). Foucault’s devolved or pluralist notion of governmentality has been represented as a continuum “between the power we have to govern ourselves, families and environment, and the sovereign power of the state” (C. Scott, 2004, p. 154). Foucault himself stated that he intended the concept to embrace not only the actions of the state but “the whole range of practices that constitute, define, organise and instrumentalise the strategies that individuals in their freedom can use in dealing with each other” (Foucault, 2003a, p. 41). He refers to the governmentality implicit in the most mundane relationships—of teacher and student, abbess and convent, and to family relationships (Foucault, 2003b).

Moving away from the regulatory governance traditions towards the sociological and philosophical roots of the governmentality does, however, requires a significant idiomatic shift. Within governmentality parlance, ‘discourse’ is spoken or written text authorising ‘fields of knowledge’ (savoir) about the way things in society ‘should be’ or are in relation to a particular conception of ‘what is problematic’. Discourses are liable to be programmed, through strategy, by those exercising power, into ‘technologies of power’ to influence the
conduct of other people, their ‘subjects’ (Foucault, 2003d).

**Assemblages of power relations**

Foucault used the notion of ‘assemblage’ to refer to the constellation of messy and multiple lines of power between influencer and subject—including the strategies employed, the written or oral discourse that fuels them, and the ‘problematisations’ from which the whole emanates (Foucault, 2003d).

The notion of an assemblage of power relations within a defined domain is particularly applicable for the present research. It is distinctly resonant of, and complementary to, the pluralist regulatory governance approaches. While the network governance approach conceptualises the mapping of stakeholders in relation to each other, the focus there remains on the stakeholder, (or the ‘node’) and their respective characteristics, motivations and capacities. In realist governmentality, by contrast, the emphasis is on the content of power relations, that is, on the linkages between nodes.

**What is a problematisation?**

The governmental notion of ‘problematisation’ is also useful for the present research. It asserts that each stakeholder acts with its own distinct view of ‘what the problem is’. Understanding the perception of a problem—especially from respective stakeholder viewpoints—delimits the range of possible policy solutions (Miller & Rose, 2008).

**Governmentality analytic**

A governmentality-inspired genealogical analytic traces the action and effect of practice and discourse comprised in expressions of influence, from its effect on the subject ‘back through’ the operative strategies and rationalities, to the originating problematisations of the influencer (Lippert & Stenson, 2010).

The association of a genealogical analytic with linear time is merely analogous, however, for “governmentality’s efficacy is the restitution of the present… [I]t writes history in the present tense” (Donzelot, 1979, p. 79). Governmentality is not about pivotal people, events or even ordered action and re-action in space and time. Its focus is the origins and effects of strategies of power, on the micro-practices of actors, on the formation of their self-identities and subjectivities (Lippert & Stenson, 2010). The non-temporal, and yet historicist, approach to the construction of the subject is core to post-structuralist genealogy, which “takes the modern subject as data to be accounted for” (Ferguson, 1991, p. 328).

Applied in the present research context, a realist governmentality analytic enables
‘track-back’: from strategies and technologies of power exercised by stakeholders in the mental health domain—including practices in relation to mental health law—to the operant objectives, including, perhaps, access to service (or not, as the case may be). These working, motivating objectives will point to particular characterisations of ‘problem’ in the mental health law and access domain as perceived by those with a particular stake in its outcomes. Better appreciation who cares about what, and of the operant power dynamics likely to be affected by the pulling of particular policy threads, should enable more precise calibration of policy—including regulatory policy—to responsively craft those outcomes.

2.2.2 CONTEMPORARY STREAMS

Early developments
Introducing governmentality, in his speech at the College de France in 1977, Foucault was initially sketchy, speaking in terms of the change in the strategic engagement of specialist knowledge since the 16th century. As Miller and Rose (2008) explain, some writers have overworked this introductory and brief set of comments, endeavouring to extract ‘the essence’ of the governmentality conceptualisation. In truth, however, governmentality began to grow and depart from Foucault’s initial outlines almost immediately. Lippert and Stenson (2010) identify, in fact, that the first programmatic statement about the workings of governmentality was not Foucault’s at all, but by Donzelot (1979).

Post-Foucauldian developments
Since Foucault, governmentality has developed a discursive, and a ‘realist’ stream (McKee, 2009). It has been used in concert with a number of other theoretical frameworks, in a wide range of disciplines, and across the spectrum of social policy (Lippert & Stenson, 2010). Governmentality now functions within the academy as an independent conceptualisation, no longer firmly yoked to the Foucauldian post-structuralist perspective.

The leading-edge governmentality analyses of Nikolas Rose and his colleague Peter Miller—in works dealing with the notion of the ‘neurochemical self’ (Rose, 2003), risk management (Rose, 2005), the role of psychiatry (Rose, 1998) and therapeutic authority (Miller & Rose, 1994)—have contributed hugely to understanding of contemporary socio-political phenomena, with particular resonance in the mental health sphere. Yet the strength of this discursive engagement with the concept may have deflected some attention from the empirical potential of the approach. Indeed it has been argued that this form of ‘discursive
governmentality’ (Stenson, 2008) has “eschew[ed] empirical description and realist institutional analysis” (McKee, 2009, p. 473), contributing to a perception that governmentality scholars are excessively concerned with discourse, politics and ideology, and not useful for researchers “interested in the effects of power at the micro-level and the lived experience of subjection” (McKee, 2009, p. 474).

2.2.3 REALIST GOVERNMENTALITY

A second strand of post-Foucauldian scholarship—realist governmentality—explores the particularities of the response of the subject to attempted influence. Realist governmentality returns governmentality to the field, to the effects, in practice, of the exercise of technologies of power by would-be governors, and to the forms, in practice, of the exercise of compliance and resistance by subjects.

Back to basics?
Despite possible post-structuralist criticisms of “ontological gerrymandering” (Woolgar & Pawluch, 2004, p. 45), it is arguable that realist governmentality is, in fact, a return from discursive governmentality’s obsession with neo-liberal state rationalities to Foucault’s broader conceptualisation and his predilections for the factual, obscure minutiae of everyday life (McKee, 2009). Lippert and Stenson (2010) expressly identify that governmentality does not ‘belong’ only to the state but applies in any relation of influence. Foucault himself said that governmentality applied as much to ordinary families as to the government of institutions (Foucault, 2003a). His suggested approach to analysis was firmly empirical:

I would like to suggest another way...a way that is more empirical, more directly related to our present situation, and one that implies more relations between theory and practice. It consists in taking the forms of resistance...as a starting point...[I]t consists in using this resistance as a chemical catalyst so as to bring to light power relations, locate their position, find out their point of application and the methods used. Rather than analyzing power from the point of view of its internal rationality, it consists of analyzing power relations through the antagonism of strategies.

(Foucault, 2003d, p. 790)

Examples of empirical realist governmentality
Embracing the capacity of realist governmentality to reveal specific, grounded relations of power, and possible gaps between expressed policy and subject response, the last two
decades have seen strong growth in realist governmentality studies applied in various social policy contexts. These include: John Clarke’s analysis of consumerism in the UK (Clarke, 2006); a study of welfare-reliant women’s response to reforms in the US and the Netherlands (Korteweg, 2006); child and youth welfare in Germany (Kessl, 2006); men and boys in public policy in Australia (Pease, 2006); and access to assisted reproductive technologies (Smith, 2006). Other realist governmentality studies have addressed: statistics (Hacking, 1990); social work (Stenson, 1993); sexual abuse (Ashenden, 1996); alcoholism (Valverde, 1998); crime prevention (Lippert, 2002); community safety (Stenson, 2008); development and gender in India (Sharma, 2008); social improvement schemes in Indonesia (Li, 2007); social housing (McKee, 2011a, 2011b); family intervention programs (Parr & Nixon, 2008), and ‘downtown ambassadors’ for police (Sleiman & Lippert, 2010). The classic governmentality-based study of the pervasive, and yet camouflaged, control strategies in action at Disney World was conducted by Clifford Shearing and Phillip Stenning (Shearing & Stenning, 1985).

The realist governmentality approach to empirical research is not an attempt to establish causation, determine outcomes or find relationship between input and output variables, or even as between stakeholders with particular characteristics. Rather, the aim is to reveal the productive effect of problematisations on the generation of governmental rationalities, and then on the development of strategy and technologies of power that are extended to subjects. Distinctively, it is also about the effect of these ‘positivities’ (Foucault, 2003a) on the subject.
2.3 GOVERNANCE+GOVERNMENTALITY?

In this section, I outline a form of approach to analysis of regulatory systems, and to a recalibration of formal policy in response, that engages both network governance and realist governmentality approaches.

2.3.1 A PRODUCTIVE ANTAGONISM

The dissonance between governmentality and governance

It is, as yet, unusual to harness regulatory governance and governmentality approaches for policy analysis and development. Because of their disparate disciplinary backgrounds and their significant axiological (about norms and values), epistemological (about what is true), and ontological (about what is real) differences, scholars have approached very similar problems around control, government and regulation from either one or the other direction. McKee, for example, has noted:

[G]overnmentality…transcend[s] moral judgements about the proper form of ‘good’ and ‘democratic’ government… [T]his is in stark contrast to the mainstream governance literature which tends to focus on describing how organizations or actors are, or should be, governed.

(McKee, 2009, p. 472)

Assonance: power across space

I argue, however, that far from governance and governmentality standing together in ‘stark contrast’, their use in tandem is conceivable, rationalisable and productive. The synergy occurs specifically in their sharing of the motif of distribution of power across regulatory space. All of the public choice-oriented pluralist regulatory governance approaches pursue a notion of governance as “diffused throughout society” rather than top-down or state-centred (C. Scott, 2004, p. 166). This configuration closely resembles the contemporary governmentality focus on “little regulatory instances across a territory” (Miller & Rose, 2008, p. 25). It is precisely the contrast of perspectives at this metaphysical conjunction of power and space that has particular, illuminating potential for contemporary social policy research.

There have been signs that the potential complementarity of the approaches is beginning to receive recognition (Colebatch, 2006; Hobson, 2010). Scott (2004) explicitly
recognises similarities in the emphasis on non-sovereign power relations in both
governmentality and the newer, heterarchical governance approaches such as meta-
regulation.

**Assonance: Focus on ‘the subject’**

The analysis of subject-hood, a feature of the governmentality approach, has come to
prominence recently in governance circles through the conceptualisation of ‘nudging’, the
popular handle for the developing field of behavioural economics made popular by the
influential books *Freakonomics: A Rogue Economist Explores the Hidden Side of Everything* (Levitt
& Dubner, 2006) and *Nudge* (Thaler & Sunstein, 2008).⁵

Like governmentality, ‘nudge’ techniques address subject formation. Nudge
techniques are artful governance strategies designed to limit citizen-subject choices by
harnessing existing social norms and dynamics rather than by formal, coercive regulation
(Thaler & Sunstein, 2008). Expressed in governmentality terms, they are essentially
‘technologies-of-the-self’. But nudge techniques, though potentially the products of a
governmentality-style analysis, arise instead from a set of positivist, analytical processes.
Whilst the approach has been lauded as a ‘soft paternalism’ alternative to more formal top-
down regulation (Thaler & Sunstein, 2008), it has also been criticised as:

…a partial reading of new behavioural theories…and human cognition…
leading to the construction of public policies that seek to arbitrarily decouple
the rational and emotional components of human decision making with
deleterious social and political consequences.

*(Whitehead, Jones, & Pykett, 2011, p. 2819)*

There is also an absence of critical reflexivity in the behavioural economics approach,
built on totalised, paternalistic visions of the subject. For though ‘nudge’ techniques are
said to arise from life itself, they are, in fact, developed from principles established from a
positivist evidence base in the fields of behavioural psychology, psychiatry, cultural studies
and neuropsychology. The problem, as McKee (2009) has identified, is that the subject
envisioned in massed behavioural data may simply fail to appear at a given time and place.
In this case, even the most sophisticated nudge techniques will fail. Missing are critical

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⁵ Professors Sunstein and Thaler are currently advising the US, UK and other governments. The United
Kingdom has established a ‘Behavioural Insights Team’ nicknamed ‘the nudge unit’ at the Cabinet Office
(Behavioural Insights Team in partnership with the Cabinet Office, 2015). The NSW Government sponsors a
Behavioural Insights unit attached to the Department of Premier and Cabinet.
reflexivity on the part of the policy-makers and focus on the located subject. Compared with the sensitivity of a realist governmentality analytic, behavioural economics ignores the complexity of social relations, and is arguably a more dumbed-down, homogenising, and flat-footed approach.

**Mixed-model approaches in policy practice**

The twinning of disparate models of enquiry is not a new concept in policy practice. Existing and prospective policies are routinely evaluated by Western governments using mixed-model frameworks, combining an ethnographic method with more data-driven approaches. These ethnographic methods approximate a realist governmentality approach. Without the element of critique demanded by a governmentality-inspired study, however, ethnographic policy analysis may still involve no reflexivity, no suspension of the state’s normative agenda, and indeed, no questioning of fundamental concepts, assumptions, language or examination of the construction of policy problematisation. The constitution of the citizen subject whom the policy directly affects, and importantly, the nature and practices of resistance exercised by that subject, is available and interpretable only through the dense, pervasive filter of the dominant rationality. Further, the details of that rationality, let alone any alternative rationalities, will, most likely, not be available to the policy interrogator. Such are the critical elements, and would be the outstanding comparative benefits, of the more sensitive and sophisticated realist governmentality empiricism.

**Governmentality refines problem definition**

As Joyce (2001) has pointed out, major social change only happens when governments begin to see problems differently, as opposed to trying new fixes or even changing governments. This sort of change in perspective is of the type advocated by Nobel Prize winner Joseph Stiglitz, who has suggested that the new millennium’s global financial crisis will only fully resolve when governments move from a problematisation of “how to enforce austerity and yet encourage growth” to one of “how to ensure the welfare of most citizens” with the resources available (Stiglitz, 2012). A governmentality approach, utilised within a governance-based social policy investigation, can deliver this game-changing perspective to the resolution of complex contemporary social policy problems. Government must look both at, and past, itself.
2.3.2 OBJECTIONS AND ANSWERS

At the base of the proposed integration of approaches in this thesis is the elemental social policy quest to factor the subjective voice within an objective evidence-base (Marston & McDonald, 2006). As identified in the Introduction, however, there are potential epistemological, axiological and ontological objections to that integration.

Epistemological disparity?
The first potential difficulty is the conflict in the basis of the truth claims that underlie the critical realist regulatory governance approach and social constructivist governmentality respectively. I argue that this difficulty is mostly dealt with by the order of integration proposed, but ultimately despatched in the adoption of the pragmatic paradigm for the work overall. This latter feature was discussed comprehensively in sub-section 1.5.4 Reconciling the use of disparate approaches infra.

In relation to the first strategy, however, I propose an order of integration that incorporates a governmentality sub-project within a primary network governance project—and distinctly not vice versa. This would likely be acceptable to the post-positivist, regulatory governance theorists who, while still concerned to determine at least an approximation of an external reality, are more willing than their predecessors to accept that data is value- and culture-laden (White, 2009). Even more specifically, however, ‘new regulationist’ scholars have written on the practical value of iterated adjustment between the subjective and objective, between induction and deduction (J. Braithwaite, Coglianeese, & Levi-Faur, 2007; Parker, 1999; Shearing & Kempa, 2004).

Axiological objections
It might be objected further, however, that the application of the governmentality framework of analysis for programmatic purpose within a normative governance project is a misuse of the traditionally non-normative basis of the governmentality conceptualisation.

This point should be considered, first, in the light of the normative ambivalence of Michel Foucault himself. For there is some academic debate about the whether there are actually ‘two Foucaults’, normatively-speaking (Trainor, 2003). The more familiar, non-normative Foucault takes a neutral normative stance on power:

This is precisely a failure to see that power relations are not something that is bad in itself, that we have to break free of. I do not think that society
can exist without power relations… We all know that power is not evil. Power is games of strategy…

(Foucault, 1997, p. 298)

Elsewhere, Foucault expresses opposition to the characterisation of power relations for normative ends of any type:

Critique doesn’t have to be the premise of a deduction that concludes ‘this, then is what needs to be done’… It doesn’t have to lay down the law for the law. It isn’t a stage in a programming. It is a challenge directed to what is.

(Foucault, 2000, p. 236)

A second interpretation of Foucault’s position relates to an undercurrent, or ‘spectre’, of a certain normativity that was never expressly owned by Foucault and yet flavours much of his writing (Trainor, 2003). For notwithstanding his critical determination to simply challenge ‘what is’, Foucault’s writings reveal a very particular valorisation of freedom from domination and oppression (J. Butler, 1990; Connolly, 1993).

The entirety of the approach pursued in this thesis is pragmatic and political, and arguably closer in normative positioning to the ‘first’ rather than this ‘second’ Foucault. The primary four phases of the mixed-model framework, embedding a governmentality study within a public-choice-oriented network governance approach, is all directed to recognition of ‘what is’: to identification of multiple perspectives, interests, culture, values, regulatory strengths, regulatory strategies and the operation and effect of technologies of power in the field. I submit, then, that despite the over-arching regulatory governance framework, this thesis sustains a relatively non-normative approach to research design and analysis. It is founded on critical, assumption-testing methodology directed to the concern that policy should be made in ‘kid thyself nor’ awareness of its effects in the real.

Ontological objections
The third possible substantial base of objection to the integration of governance and governmentality approaches is ontological, and concerns Foucault’s avowed, and yet disputed, anti-essentialism. Foucault was at pains to argue that there is no fundamental, external truth or essence in any institution but rather only the product of entirely contingent discourse:
“Truth” is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation, and operation of statements.

(Foucault, 2003a, p. 317)

It might seem anomalous (again, potentially ‘un-Foucauldian’) to use a network of institutions and agents—undoubtedly ‘things’ purported to have some essence, to embody various ‘capacities’ within the network—as the context for a governmentality sub-project.

In answer to this, I argue, first, that the pragmatic paradigm absolves the present project of the need to completely close this ontological distance. Secondly, I point to the contestable nature of the anti-essentialism of Foucault himself. The voice of a located subject is a ‘something’ rather than a ‘nothing’, even if it is a construction of discourse:

…while he certainly condemned totalistic, unitary, theory-driven, ‘Truth-driven’ and ‘top-down’ theorectico-deductive systems of thought, he actually applauded and supported open, pluralistic, flexible, ‘emergent’, ‘Truth’-enfolding ‘bottom-up’ modes of theorizing. If so, we would have to say that alongside the Foucault who disbelieves in ‘Truth’, we now find a radical, activist Foucault who ardently desires to participate in the process whereby the Truth emerges or ‘grows’ into the clear light of day.

(Trainor, 2003, p. 566)

The truth claims, made in the course of the four phases of the mixed-model method pursued in this thesis will, in line with Brian Trainor’s ‘real Foucault’, be emergent, expressly contingent and pluralistic. Many will arise from reflections of the actual experience and practice of real subjects addressed in the course of empirical, realist governmentality research. These subjects will be located within a landscape of power relations that has been hypothesised initially with the aid of a network governance perspective but subject to potentially radical alteration under the governmentality micro-gaze. Thus, the governmentality approach in this form is not abstract, overly theorised, constrained by ideology, nor totalised. Rather, it is firmly empirical, it is respectful of the subjective view, and it demands reflexivity on the part of the researcher and reader.

Conclusion

This thesis asserts that the form of pragmatic integration adopted for its governance+governmentality mixed-model framework addresses, and substantially answers, possible objections in relation to disparate truth claims, value positions and ideas about what is real.
Some final words, from Foucault himself, profoundly encourage the paradigmatic departures represented in this thesis:

All my books…are, if you like, little tool boxes. If people want to open them, use a particular sentence, idea, or analysis like a screwdriver or wrench in order to short-circuit, disqualify or break up the systems of power, including eventually the very ones from which my books have issued… well, all the better!

(Foucault, 1989, p. 149)

2.3.3 INTRODUCING THE MIXED MODEL METHODOLOGY

In the next sections of this thesis, I will describe elements of the methodology, both as designed for, and as applied to, the instant mental health law and access project.

The methodology describes a mixed-model governance+governmentality approach in four phases. The methodology is constituted as a single project featuring two qualitative sub-studies—one utilising a network governance approach and the other, a form of realist governmentality analytics. These are represented in a sequential process within the four-phased methodology as follows:

- Phase I—Scoping
- Phase II—Network governance study
- Phase III—Realist governmentality study
- Phase IV—Synthesis

The methodology associated with each of these Phases is set out in the balance of this chapter.

The methodology is designed to address a practical regulatory policy problematisation about the effect of risk-based, mental health law on access to mental health services. It was not feasible, however, within the time and cost restraints of this PhD candidacy, to apply it with optimum scope in the field. The modifications necessary to meet the practical constraints will be explained in each Phase of the field method explicated in the following sections.
2.4 PHASE I SCOPING METHODOLOGY

Phase I Scoping provides an investigative anchor for the subsequent studies and synthesis. The principal tasks in this Phase are first, the formulation of the policy problematisation founding the research questions, and secondly, identification of the membership of the regulatory domain of interest to be investigated.

2.4.1 THE PROBLEMATISATION

Problematisation as construction

The notions of ‘government’ and ‘problems’ are closely related. Miller and Rose (2008) argue that the need for governing—for policy, for regulation—arises only where the ungoverned state of affairs is recognised as problematic in some way.

But is the existence of a policy problem objectively determinable? It is certainly true that the quickest means to solve a problem is to simply to declare it ‘not a problem’. It has been argued that the identification of a policy problem is entirely a social construct (Colebatch, 2006). A problem does not exist unless and until it is made visible and named in public discourse (Miller & Rose, 2008). This is the process of problematisation.

The definition of a policy problem may, however, be as contested as the solution. From the same facts there may be a number of perspectives about whether they represent a problem, and if so, of what sort. The absence of reflexivity about the subjective character of policy problematising may be a significant cause of policy misfire.

This thesis project is conducted with appreciation that effective, responsive policy design requires appreciation of the socially constructed nature of a policy problematisation, of the possibility that it will change in the course of research, and of the probability that other stakeholders’ versions of the problematisation may need to be factored in future decision-making.

The identity of the problematiser

The first task of Phase I Scoping is to develop a ‘starting’ problematisation for the overall study. So who is the relevant ‘problematiser’? In usual policy practice, and in mainstream academic social policy research, the relevant problematiser is the investigating stakeholder or
researcher, whether or not they adopt a reflexive position in relation to it, and whether or not they attend to other views on the problematisation in the course of the work.

The post-positivist regulatory governance perspective of this thesis, however, would arguably permit a problematisation from the perspective of the common good, relating to the identification of ‘good’ or ‘better’ regulatory governance in the mental health sector, however normatively slippery such a formulation might be. Alternatively, again, the thesis might adopt the problematisation of a particular stakeholder, such as the state.

Most suitably for the purposes of this thesis which, despite its over-arching post-positivist framework, explicates only interpretive, qualitative research, I choose to be explicit about the subjective basis of the primary problematisation for this research. The primary perspective is my own, founded in my particular academic and social interests. As presaged in the Introduction, these interests include: concern for better care and treatment of people with mental health conditions now and into the future; interest in analysis of processes and technologies for governing behaviour; interests in the rationalities of law; and in regulatory governance, therapeutic jurisprudence, and social justice generally.

Statement of the problematisation
Accordingly, the problematisation of risk-based mental health law in relation to access for this thesis is:

*Access to treatment and care for people with serious mental illness is a major and increasing problem in Australian society. Risk-based mental health law is posited by the state as a policy instrument that facilitates access. Is this true? If not, what does it do?*

As projected in the Introduction, the research question for the mixed-model study the subject of this thesis, developed from this problematisation, is:

*What is the effect of the risk-based model of Australian mental health law on its objective to facilitate access to mental health service?*

### 2.4.2 Hypothesising the Regulatory Domain

What is a regulatory domain?

The second task in Phase I Scoping requires identification of members of the regulatory domain of concern. This set may include individuals, organisations, groups of
organisations, citizens with common interest, the state, parts of the state, the media…in fact, any agents who possess a stake in the outcomes of a particular policy problematisation. In this methodology, these agents are referred to as stakeholders in the regulatory domain. A particular meta-regulatory map of stakeholders is not equivalent with a map of interaction, of communications, or of functional association between stakeholders. It does not purport to be a ‘closed system’ (Teubner, 1987) nor to represent any type of totalised or fixed construct.

**Calibrating the domain**
Pragmatically, the definition of the domain should be calibrated to the scope of the founding problematisation, and also to the practical context of the research. A broad problematisation arising in relation to the regulation of holiday rental properties in regional New South Wales, for example, might identify all shire councils in that state as a single stakeholder. A problematisation about management of environmental matters in the state’s Namoi region of New South Wales might identify the five town councils as separate institutional actors.

There is no suggestion within the founding problematisation, or in the research question for the present project, that the designation of stakeholder categories should be other than broad. There is no attendance to any particular within-Australia geographic or jurisdictional differences, to the epidemiology of mental health problems, or to variations in mental health need, source of funding or distribution of services. The relevant ‘starting’ domain then is the entire Australian mental health sector (in all of its jurisdictional complexity, as described in the Introduction).

**Location**
Time and resource constraints pertaining to this PhD candidature, however, require restriction of the locus of the domain in the Phase III realist governmentality study. For reasons more fully detailed in Chapter 4 below, only five of the eight state-level Australian mental health jurisdictions are represented in the governmentality sub-study. These jurisdictions—New South Wales, Victoria, Tasmania, South Australia and the Australian Capital Territory—are referred to, in this thesis, as ‘the Phase III jurisdictions’.

**Membership**
The specific technology the focus of the relevant problematisation—risk-based mental health law—is a regulatory technology exercised by the authority of the state, which is delegated to public psychiatrists to enable them to involuntarily treat and detain consumers.
of mental health services, for the consumer’s benefit and protection, but also for the protection of the larger community. The four principal stakeholders in relation to the relevant problematisation, therefore, are Australian state and territory governments (“the state”), public psychiatrists, the community, and consumers of mental health services.

Beyond this group, other actors are also clearly implicated, such as the community-based services sector, which delivers some publicly-funded mental health services; family and carers, who are often instrumental in the initiation of mental health orders, and who are often the default service providers when state or private services are not accessed; and the media, which reports on mental health issues such as access to services, funding, adverse events and public safety, and which is, arguably, responsible for the direction of public attitudes, and for both the dissipation and generation of political capital in mental health issues.

Because of the restrictions of time and resourcing for this thesis project, however, a membership of only the four principal stakeholders is proposed. This membership will apply to the project overall and in the Phase II Network governance sub-study. It will be referred to as the ‘mental health law and access domain’.

Further restriction in focus will be necessary for the Phase III Realist governmentality sub-study, as resource constraints do not permit fine-grained analysis of the relations of all potential dyads even within the adjusted set of four domain members for the overall project. I propose, therefore, to investigate relations of influence only in dyads that include public psychiatrists—either in the role of ‘influencer’ or ‘subject’. I choose this stakeholder because of the centrality of their role in relation to both the technology of mental health law, the provision of treatment and care, and because of their relative accessibility as subjects for research. I acknowledge that the absence of evidence from dyads that do not include psychiatrists—and perhaps, especially, direct evidence of the perspective of consumers—limits the scope of the study to answer the overall research question as it relates to the domain as a whole.

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6 In this thesis, the word ‘community’ refers to the larger society—‘the public’.
2.5.1 PHASE II RESEARCH QUESTIONS

The task of this thesis is to gauge the effect of the use of a particular regulatory technology, mental health law, in relation to a particular policy objective, access, in a complex policy domain where multiple stakeholders are engaged in prosecuting multiple strategies of influence towards the achievement of multiple, competing objectives. The particular role of the Phase II Network governance sub-study is to marshal understanding, within that morass of plurality, of the importance of the access objective as a function of relative influence of respective stakeholders and their agenda. Phase II should also reveal the underlying drivers and values that affect the formation of interests, and the level and form of exercise of a stakeholder’s regulatory capacity.

Thus, the research questions for the Phase II network governance sub-study have been formulated as follows:

- What are the relevant stakeholders’ interests, values, and culture?
- What factors affect each stakeholder’s capacity to influence outcomes in the domain in the direction of their interests?
- What is the regulatory capacity of each stakeholder relative to others in the domain?
- What is the salience of the ‘access’ interest relative to other operative interests within the domain?

2.5.2 CHOOSING A RESEARCH METHOD

Method criteria for Phase II

To effectively address the research questions, the research method chosen for Phase II must enable analysis of an individual stakeholder’s regulatory capacity, and the relativising of competing objectives. Further, and as a counterpoint to the located intimacy of the Phase III sub-study’s approach to practice, the Phase II method should also be able to canvas the broadest possible scope of evidence of the capacity and objectives of the stakeholders in the
mental health law and access domain. Lastly, the method must suit the practical context of unfunded, sole researcher, time-constrained doctoral study, in the context of a mixed-model approach.

Suitability of a literature-based method

There are no definitive methods for the conduct of network governance research. Scholarship has largely been conducted discursively rather than in the field (C. Scott & Brown, 2010). To proceed in a literature-based mode for the Phase II sub-study, however, satisfies the criteria as described above. As the mental health law and access domain is a current and long-standing policy domain, a literature review unleashes evidence relevant to the understanding of the capacities to influence within it, in the form of academic studies, policy documents, media and user reports, and government analyses—with considerable range geographically, and across media, publishing context, and academic tradition.

Furthermore, the developed literature review methodology in recent decades (Dixon-Woods, Bonas, et al., 2006) provides options for dealing with the range of material, the range of the instant inquiry, and particular elements of approach to interrogating stakeholders’ capacity and agenda.

Further again, a literature-based approach is an achievable undertaking in the practical context of this mixed-model research and my PhD candidature.

Which literature review method?

Older forms of literature-based policy research sought to analyse the existing evidence-base to generate a summary of what has ‘worked’ in the past (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005). But there is a deficit of nuanced, political intelligence available from mere aggregation. Mary Dixon-Woods and her colleagues researched a range of literature review methods eventually developing a new method they called ‘critical interpretive synthesis’ (CIS). It was designed for application to large, heterogenous literatures and to ‘messy’ research problems, where a method with “explicit orientation towards theory generation” would be a good fit (Dixon-Woods et al., 2005, n.p.). I have chosen to employ a modified CIS method for Phase II of the methodology described in this thesis because, similarly, the Phase II sub-study has been particularly positioned for critique and for theory generation, and because the relevant literature base is large and heterogenous.
2.5.3 INCORPORATING THE NATO AND AI FRAMEWORK

The principal modification of Mary Dixon-Wood’s (2006) critical interpretive synthesis method for purposes of the Phase II Network governance sub-study is the incorporation, at the analysis stage, of a query framework based on what is arguably the principal tool in the field for analysis of regulatory capacity—Scott’s (2010) NATO (Nodality, Authority, Treasure and Organisation) conceptualisation. I have added my concept of agenda identity (AI) to form the ‘NATO/AI query framework’

As briefly described in the Introduction, within the NATO heuristic, ‘nodality’ addresses the connectedness of a stakeholder in a network. ‘nodality’ refers to a stakeholder’s ability to maximise the critical mass of its regulatory influence by communicating directly with other stakeholders in networks, gathering and trading interests and information.

Authority, in the NATO heuristic, refers to a stakeholder’s formal capacity to discipline, to ‘tackle cowboys’ (C. Scott & Brown, 2010), and to enforce its agenda on other stakeholders. It is about the size of the stakeholder’s ‘official’ regulatory muscle. Non-state actors may have substantial regulatory authority.

The notion of ‘treasure’ concerns the capacity of a stakeholder to accrue and mobilise resources that are then utilised to ‘fund’ the achievement of the stakeholder’s objectives (Hancher & Moran, 1989). These would often be financial resources. I extend the concept of regulatory currency or ‘treasure’, however, to non-financial resources such as electoral power, or a particular skill or characteristic that is pivotal to the interests of other stakeholders.

Organisation refers to the structural characteristics of the agency that enables it to mobilise to ‘get things done’ (C. Scott & Brown, 2010). A high level of organisation may be expected of a powerful regulatory actor.

My concept of agenda identity refers to the culture, values and interests that influence the stakeholder’s action and response towards other stakeholders, its factoring of relevant externalities, and its perception of the difference between the actual and desired state of things (J. Paterson & Teubner, 1998).

Culture is defined as: “the sum total of ways of living built up by a group of human beings, which is transmitted from one generation to another…” (“Culture”, 2015). The importance of culture to the regulatory orientation of agents in many policy fields has been extensively studied (Clark, 2002; Psimmenos & Kassimati, 2003; Reiman & Norros, 2002).
A stakeholder’s values, by contrast, may be less tangibly apparent, and yet perform as powerful determinants of practice. Values are: “the things of social life (ideals, customs, institutions etc.) towards which the people of the group have an affective regard” (“Value”, 2015). Examples of studies on the impact of values on policy development exist in nanotechnology (Ho, Scheufele, & Corley, 2010); on school food policy options (Worsley, 2006); in agriculture (Schoon & Te Grotenhuis, 2000); in drug treatment (Valentine, 2009); in relation to the climate (Leiserowitz, 2006), and in mental health (Fulford, 2011).

A stakeholder’s interests conveys notions of benefit or advantage (“Interest”, 2015). The study of interests has a strong provenance in public policy, in political science but also in the regulatory governance literature. There is a difference between ‘real’ and ‘perceived’ interests (B. Morgan & Yeung, 2007; Thaler & Sunstein, 2008). The motivating ‘perceived interests’ are a particular concern in the Phase II sub-study.

2.5.4 ESTABLISHING A SAMPLING FRAME

Establishing a sampling frame
Relying solely on protocol-driven database searches for the review of a complex evidence base has been discredited as ineffective and unwieldy (Dixon-Woods, Cavers, et al., 2006; Greenhalgh & Peacock, 2005). Instead, the methodology for this thesis relies on a workable, productive and sensitive sampling frame formed accretively by iterative processes of database searching, web searching, citation “tracking” (that is, following the citations of citations of particularly relevant papers), and the application of researcher resources (Dixon-Woods, Cavers, et al., 2006; Greenhalgh & Peacock, 2005).

Construction of the sampling frame involved two distinct and yet overlapping searching stages—scoping and mapping (Thomson, 2012). The first stage, scoping, required the collection of relevant references and initial generation of a sampling frame, with the aim to generate a manageable, representative data set. The second stage, mapping, involved grouping components of the sampling frame by elements of meta-data related to the topography of the sampling frame, as filtered by the NATO/AI query framework. This was, as Dixon-Woods (2006) suggests it would be, a messy, iterative and necessarily incomplete process.
Scoping
Early electronic searching trials using terminology specific to the network governance perspective (e.g. ‘regulation’, ‘regulatory capacity’, ‘nodality’, and ‘network’) were not fruitful. It was concluded, not unsurprisingly, that a network governance perspective, and in particular application of the NATO perspective, had not been reported in the mental health field.

But these initial trials did identify an approach in the mental health literature that related to the genre of meta-regulation. This was the application of systems theory to mental health policy analysis (McCubbin & Cohen, 1999; Stone, 2003). Castell’s theory of the network society is also aligned (Castells, 2000). Both of these alternative approaches identify the multinomial complexity of policy drivers and policy actors for outcomes within the sector and so, arguably, represent a meta-regulatory perspective. Accordingly, this literature was afforded representation in the sampling frame.

However, in the absence of specific studies in the field utilising the selected theoretical perspective specifically, it was necessary to identify broader inclusion criteria, arising from the essence of the research questions.

The final, and most productive, electronic search protocol underpinning the web-based contribution towards formation of the sampling framework was:

(mental health policy) AND stakeholder AND (power OR politics OR values OR interests).

This protocol was applied to searches in the Ovid, the Social Sciences Citation Index, Scopus and Proquest databases.

Revising the scope
This wider approach did, however, elicit several tens of thousands of potentially relevant pieces of literature. In the context of unfunded, single-investigator research, coverage of this set of returns was unfeasible. Following Dixon-Wood’s approach in similar circumstances, the purpose of the scoping stage was then re-framed—from an attempt to identify each item of literature relevant to the research questions, to the collation of a database of relevant references of manageable size within a reasonable time-frame.

This was achieved, in the Phase II study, by the use of filters, and by diversification of the collection method.
Filters

Initial electronic search returns were scanned with critical application of the following filters:

- relevance (assessed by reference to elements of the NATO regulatory capacity model);
- recency (2002 to 2012);
- the featuring of stakeholders of interest—namely, the state, public psychiatrists, the community and consumers;
- being a contribution to a principal discourse in the field over the period of interest;
- exclusion of returns not related to British, North American and European mental health jurisdictions; and
- privileging of Australian and New Zealand sources.

These application of these final two criteria, related to the jurisdictions in which stakeholders operated, ensured that data addressing regulatory capacity and agenda identity were drawn only from Western countries with risk-oriented mental health laws. There are clearly differences between the mental health laws and service systems of those countries, as there are differences between the laws and service systems of the eight Australian mental health jurisdictions. What particularly matters for the Phase II research questions, however, is stakeholder orientation within policy-oriented issues or ‘conversations’ of the time (see Table 2). These conversations are common to Western, risk-based mental health jurisdictions, including Australian ones. The various perspectives within them, however, are not appropriately represented in the relatively small quantity of Australian-oriented literature alone.

These filtering criteria were applied to a large-scale, though by no means exhaustive, review of the electronic returns, with a view to extracting a much smaller, secondary, sampling framework. This process was assisted by the relevance ordering function of electronic database technologies, and indications of sufficiency in relation to discourse identification.

Diversification of collection method

Like Greenhalgh (2005), however, it was found that the scanning of the database search returns, along with the critical application of the filter criteria, took a great deal of time with relatively few additions to the sampling framework to show for it.
More productive results, in terms to additions to the sampling frame, were obtained by “citation-tracking” and electronic searches of relevant journals such as the ‘International Journal of Mental Health Systems’; ‘Health Politics, Policy and the Law’; ‘Public Mental Health’, and ‘Health, Economics, Policy and the Law’.

Following Greenhalgh (2005), Dixon-Woods (2006) and Thomas and Harden (2008), the electronic output was then supplemented by the product of searches resulting from invitations to colleagues and local experts for contribution of relevant references, and the searching of my own personal reference library.

The revised sampling frame, at the conclusion of the scoping stage, numbered 251 documents.

2.5.5 MAPPING WITHIN THE SAMPLING FRAME

A second, ‘mapping’ stage of the review involved a second pass through the whole of the literature of the sampling frame to identify its ‘topographical’ features, and its relations to the mental health law and access domain.

The revised sampling frame was reviewed in its entirety and then ‘mapped’ for authorial country of origin, literature type, field of research (to indicate epistemological basis), ‘conversations’ within the field over the period (within, and across which, several dominant discourses were represented), and relevance to the assessment of the regulatory capacity and/or agenda identity of one or more of the domain members. Sources were rated 1 to 5 for relevance to elements of a particular stakeholder’s NATO/AI. If appearing in the sampling sub-frame of more than one stakeholder, an individual document might be allocated a number of different relevance ratings.

The range of entries in these five structural areas is set out in Table 2 below:
Table 2

Structural elements of the mental health law and access CIS database.

<table>
<thead>
<tr>
<th>Authorial origin</th>
<th>Field of origin</th>
<th>Literature type</th>
<th>'Conversation'</th>
<th>Domain member relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>Policy and political science.</td>
<td>Academic or professional</td>
<td>Consumer participation.</td>
<td>State</td>
</tr>
<tr>
<td>North America</td>
<td>Psychiatry</td>
<td>Media publication.</td>
<td>Psychiatric decision-making.</td>
<td>Consumer</td>
</tr>
<tr>
<td>Europe</td>
<td>Psychiatry and the law.</td>
<td>Book or chapter.</td>
<td>Risk and dangerousness.</td>
<td>Public</td>
</tr>
<tr>
<td>Australia/NZ</td>
<td>Medical (incl. medical social science).</td>
<td>'Grey' literature.</td>
<td>Control and access.</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Other</td>
<td>Ethics and philosophy (incl. medical ethics).</td>
<td>Website/blog.</td>
<td>Need</td>
<td>Community</td>
</tr>
<tr>
<td></td>
<td>Sociology</td>
<td>Other</td>
<td>Policy-making in mental health.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
<td>Public attitudes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Blame, moral distress, other psychiatrist concerns.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Stigma</td>
<td></td>
</tr>
</tbody>
</table>

During the mapping exercise, a number of references were identified as low-relevance, or as duplicates, and were discarded. At the conclusion of the mapping exercise, the initial sampling frame contained 226 references.

2.5.6 SAMPLING AND DATA EXTRACTION

The Phase II network governance sub-study method employed a mixture of purposive and theoretical sampling. Purposive sampling of the sources most relevant to elements of the NATO/AI query framework was necessary initially, but theoretical sampling was also performed to ensure that the different ‘conversations’ about issues and the contested discourses were identified, and emerging theory tested.

How large a sample?

The size of a sample depends on the size, accessibility and heterogeneity of the relevant literature, the level of debate, practical issues (Baker & Edwards, 2012) and the point at which
the necessary amount of data is reached (Dey, 1999). Dey’s conception of ‘sufficiency’ (Dey, 1999) was preferred to the Glaserian ‘saturation’ (Glaser, 1992) which requires that all ideas be accounted for. In the case of the instant research, saturation was judged to be unfeasible—each item in the sampling frame would almost certainly have contained at least one new idea. By contrast, sufficiency is reached when the categories seem to cope adequately with new data without requiring continual extensions and modifications (Dey, 1999), a more practical aim for the nature of the data to hand.

**Sampling and data extraction strategy**

Sampling and data collection was a recursive and messy process of category creation, category refinement, purposive sampling from the frame, and additional data collection by theoretical sampling, both from within the frame, and to supplement it. The process continued for each of the state, public psychiatrist, community and consumer groupings until sufficiency had been reached.

Sampling and data extraction proceeded by relevance groupings per stakeholder. Items rated in the mapping stage as being of a relevance of 4 or 5 in a particular stakeholder category were read in their entirety (or if a book, in the entirety of the sections that were relevant), annotated and thematically coded in detail. Items mapped 1 to 3 for relevance were thematically coded, at the least, by review of the abstract (if there was one), or by general perusal of the item content.

The analytic themes identified initially tended to naiveté in terms of representing the perspective of the first source generating them. Over time, however, categories developed a more objective quality, identifying debates representing the views of a number of competing perspectives in relation to power, politics and policy within the sector over the relevant period. This clarified my appreciation that effective critique can only arise after becoming familiar with a range of perspectives overall. Concurrent theoretical sampling ensured that, once principal issues were identified, a range of perspectives was obtained.

**Continuing review of the sampling frame**

The process of sampling did involve iterative review of the sampling frame as further citation-tracking revealed potentially useful additions. At the conclusion of the sampling, data extraction and synthesis process per stakeholder, the sampling frame overall included 248 documents. Many items of literature contained useful data in more than one of the stakeholder categories.
Software employed  
The respective bibliographies were managed and annotated using Mendeley bibliographic software. Thematic analyses and subsequent synthesis construction was conducted with the assistance of mind-mapping software.

2.5.7 SYNTHESIS

The fundamental task for the final stage of the Phase II method, interpretive synthesis, is creation of a synthetic argument that is more than the mere sum of its evidential parts—“to push beyond the original data to a fresh interpretation of the phenomena under review” (Barnett-Page & Thomas, 2009, p. 61). Overall, the desired product of synthesis for the network governance sub-study is the development of theory that confirms membership of the domain of interest, and that characterises and relativises those members’ influential capacities and agenda.

The method of synthesis undertaken for the network governance sub-study involved development of synthetic constructs and emergence of the synthetic argument in a continuous dialect, following, for the most part, the CIS method as outlined by Dixon-Woods et al.

Developing synthetic constructs

My synthesis commenced with a method analogous to memo-writing in the grounded theory tradition (Glaser, 1978), utilising the ‘brainstorm’ function of the mind-mapping software, and a pen and paper. In this process, I sought to identify how the thematic categories interconnected and off-set each other, looking for a ‘higher’ level of logic. I sought also to apply a NATO/Al lens to the thematic categories, gently shifting my perspective on the freely-developed data to address the specific research objectives of the study. I continued with this visual, conceptual process until the elements of synthesis coalesced into thinkable constructs, characterising both the parts and the whole of the regulatory capacity and agenda identity of each of the four actors under investigation.

Developing a synthetic argument

From time to time, I did move a thematic category into status as a construct belonging in the synthesis, if not as a synthetic construct in itself. For the most part, however, the creation of the synthesis involved effort to integrate, a process of finding the ‘story’ or the argument
lying almost but not quite beyond the data, connecting constructs in the context of the research questions. This process was similar to Glaser’s (1978) derivation of the ‘core category’.

**Finding a ‘principal synthetic construct’ for each stakeholder**

Having developed the synthetic constructs illustrating the relation of ideas within the primary sources for each stakeholder, and setting them against each other to form the synthetic argument, I sought further then to develop an over-arching or characterising construct—Dixon-Wood’s ‘principal synthetic construct’ (Dixon-Woods, Cavers, et al., 2006). The principal synthetic construct and the synthetic argument form the basis for the synthesis conducted for each actor in relation to their capacity to influence.

**Assessing relative capacity and the salience of the access objective**

The final two research questions for the Phase II sub-study (set out at sub-section 2.5.1 Phase II Research questions), relating to the salience of the access objective and the relative regulatory capacity of each stakeholder, required an additional, and marginally different, form of synthesis to the one described above.

The principal synthetic construct relating to the _relative regulatory capacity of the stakeholders_ is the final resultant ordering of the regulatory capacity of each actor formed by relativising the synthetic constructs describing the capacity of each stakeholder.

Similarly, _the salience of the access objective_ in the domain overall was a principal synthetic construct generated from earlier synthetic constructs estimating the strength of the access objective per stakeholder.

Without attempting a particularly ‘scientific’ process for estimating relativities, indices of effect magnitude may nevertheless be useful in a meta-synthesis process (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004). In the Phase II sub-study, summary ratings of each stakeholder’s capacity to influence were confined to broad qualitative descriptors such as ‘high’, ‘medium’ and ‘low’. As will be seen from the results, however, the final relative synthetic construct in each case was formed from more nuanced synthetic argument than from these descriptors alone.
2.5.8 CONFIRMABILITY

Evidence of trustworthiness
In an evidence-obsessed world, it is now considered desirable, particularly for use of the methodology in a policy-making context, that there be checks and balances (Dixon-Woods, Cavers, et al.) to ensure that the particular construction reached in qualitative research is supported by the evidence, and is not a mere a flight of fancy on the part of the researcher (Morse, Barrett, Mayan, Olson, & Spiers, 2008).

This is despite that, academically at least, the interpretive, ‘art’ element in constructivist approaches, such as the critical interpretive synthesis method utilised in the Phase II sub-study, and in grounded theory analysis, has, in more recent times, been specifically validated (Charmaz, 2003; Strauss & Corbin, 2008). If the method applied is properly ‘grounded’, and the researcher theoretically sensitive, each researcher’s synthetic product in relation to a particular data set should be considered as valid and reliable as the next (Guba & Lincoln, 1982).

A bridge between the paradigms?
The notions of validity and reliability are part of the tests for academic rigour in the experimental, positivist paradigm. Yet it has been relatively recently argued by Morse (2008) that these older, positivist terms and concepts may be transferable to constructivist, qualitative study. Morse’ argument that verification is integral to good qualitative design, and is thus part of the qualitative researcher’s responsibility, represents a possible bridge between the paradigms.

Demonstrating ‘validity’ (or confirmability)
On the other hand, the transfer of the validity methods from the experimental world presents practical difficulty in many qualitative research contexts (Golafshani, 2003). Because of the interpretive processes involved, replication of results by employing a data or methodological triangulation can be difficult to arrange. Ideally, there would be within-study provision for revision of the synthesis after checking initial results using, say, an author-survey method, or, as did Dixon-Wood et al, the considerations of a large, multi-disciplinary research team (Dixon-Woods, Cavers, et al., 2006). In the performance of the mixed-model study for this doctoral thesis, however, there were insufficient resources for the complex process of seeking and obtaining feedback from the many, geographically-disparate authors featured in the review, and no scope for team discussions.
Confirmability in the Phase II study

To demonstrate confirmability of the Phase II study results, I rely instead on the prosecution of within-study verification strategies, such as those described by Morse et al (2008). In earlier sections of the description of this method, I have described my investigator responsiveness to challenges arising in data classification; the methodological coherence between the research questions of the sub-study and the method; sampling adequacy generating a significant total number of literature items reviewed from initially purposive and then theoretical sampling; concurrent collection and analysis of data; theoretical thinking with a clear, iterative process, with particular care in the integration of the NATO framework; and finally, in the sections of this thesis below, in the presentation of cohesive, sustainable theory about the basis of the relative capacity to influence, agenda identity and salience of the access objective in the mental health law and access policy domain.
2.6 PHASE III REALIST GOVERNMENTALITY SUB-STUDY METHODOLOGY

2.6.1 ELEMENTS OF GOVERNMENTALITY ASSEMBLAGE

Whereas the aim of the Phase II Network governance sub-study was to characterise the content of the nodes in the meta-regulatory map of the mental health law and access domain, the aim of the Phase III Realist governmentality sub-study was to render thinkable, and to analyse, the productive action of power between the nodes.

In this section of the thesis, I will describe generic elements of the field of power relations between a governor (influencer) and the governee (subject) towards explication of a strategy to investigate these in the context of the research questions for the realist governmentality sub-study.

Relevant concepts, on the governing side of power relations, include ‘objectives’, ‘rationalities’, ‘strategies’ (includes ‘vectors of influence’), and ‘technologies’ of power. At the receiving end of a vector of influence expressed by a would-be governor, the focus is on the action of the subject, including ‘action externally’ (to the subject) and ‘actions-on-the-self’ (Foucault, 2003a).

Technologies of power
Technologies of power are the vehicles, programmes, or sets of practices employed for implementing the strategy of a would-be governor (Lippert & Stenson, 2010). Technologies of power are intended to circumscribe the range of possible actions by the subject (Foucault, 2003d; Lemke, 2002). Various sub-types have been recognised including: technologies of domination (Foucault, 2003a); technologies of exploitation (Foucault, 2003a); technologies of agency (McKee, 2011b), and technologies of citizenship (McKee, 2009). ‘Technologies-of-the-self’ are programmes undertaken by an influencer to shape the subject’s sense of themselves—who they should ‘be’, what they should aspire to, and be responsible for—and to mobilise the subject’s choice of action in a direction congruent with the would-be governor’s interests (Foucault, 2003c).

Foucault clearly envisaged that the enactment of governmental strategy may involve the overlap and integration of more than one technology (Foucault, 1993).
Strategies and vectors of influence

Governmental strategies organise technologies as expressions of power in the service of the ultimate objectives of the actor (Foucault, 2003d). The use of governmental analytic method in the investigation of strategies can point to serious disjuncture between the objectives and the expressed rationalities of government (Dean, 2009; Lippert & Stenson, 2010).

For greater clarity in distinguishing empirical elements in fieldwork and analysis, I have chosen to discriminate, *within* the conceptualisation of strategy, between the overall plan, and its outward-moving expressions. I use the term ‘vector of influence’ to denote these singular, energised distillations of elements of strategy. They take form as practice and/or discourse and are conveyed to the subject by a technology of power. Strategies are nests of such vectors and their associated technologies, and may involve actors other than the would-be governor and subject in the empirical spotlight. Vectors of influence identified empirically underpin inference of the broader, plan-oriented strategies at work, whilst being inseparably part of them.

Rationalities

A rationality is a ‘truth claim’ or value statement and comprises moral justification to exercise influence in particular ways (Lippert & Stenson, 2010; Miller & Rose, 2008). Rationalities are statements (Foucault, 2003f). They can be represented in programmatic texts, like laws, policy, archival documents, and other textual data and, as Lippert and Stenson (2010) remind us, in oral discourse also. The strategically impelled technologies of power adhere to, and take moral ‘fuel’ from, rationalities (Foucault, 2003d), and are filtered in their logic and composition by strategy. This is the productive ‘knowledge-power nexus’ that particularly distinguishes Foucault’s conceptualisation of power relations (Foucault, 2003d).

Rationalities cluster around particular sets of conditions in society. These clusters are not an “ensemble of truths to be discovered and accepted” (Foucault, 2003f, p. 317) but rather a specific organisation of what is true and what is false, of what is valued and what is not, of what is dangerous or threatening and what is not (Foucault, 2003c). The form that makes this collection of moral positions a possible object of thought is the ‘problematisation’, as described earlier in this Chapter. One aim of a genealogical analytic of government is to discern the connection between technologies of power and the problematisations produced and sustained by a particular organisation of governmental rationalities (Foucault, 2003f, 2003g).
Objectives

One of the more recent distinctions in governmentality thought identifies the possibility of “inconvenient dissonance” between the expressed rationalities of an influencer and its apparent objectives, as revealed by the effects, in the real, of the strategic regimes of practice (Dean, 2009, p. 4; also Gordon, 1980):

The domain of effects cannot be read off the programmes of government themselves. Explicit theoretical and programmatic rationality thus enters practices and may be deciphered within them, but it never exhausts.

(Dean, 2006, p. 29)

The part of practice not exhausted by rationality may only be inferred from the logic of apparent strategy in the whole of a set of power relations. This capacity to critically identify pivotal motivations in what is unsaid by a would-be governor is a major contribution of the genealogical analytic of government towards genuinely reflexive governance (Marston & McDonald, 2012).

The subject’s freedom in response

The intended effect of an technology of power—in fact, the aim of government—is to narrow or de-limit the range of possible responses, “to structure the possible field of the action of others” (Foucault, 2003d, p. 138). But subjects are still free to choose their response: “power relations are possible only insofar as the subjects are free” (Foucault, 2003a, p. 34).

The range of a subject’s response to an expression of power is variously and fascinatingly presented by a number of writers in other politically-oriented academic traditions. An oft-quote image is Lipsky’s (1980) street-level bureaucrat, whose practice in implementing policy at the front-line involves the exercise of discretion that may vary considerably from policy-makers’ intentions and objectives. Prior (2009) focusses on the subversive reactions of ‘counter-agents’, who may be either policy implementers or subjects. Their positions include: ‘revision’ (where the implementer or subject amends or adds to the action required by policy to suit their own idea about what the outcomes should be); ‘resistance’ (where the implementer or subject takes action directly counter to the policy objectives); and ‘refusal’ (where the implementer or subject simply does not engage with the policy).

Valerie Braithwaite’s popular ‘motivational postures’ heuristic provides a second characterisation of the range of subject’s possible answers to power. Braithwaite
investigated attitudes in the context of regulation to improve the quality of care in nursing homes. Responses of regulatee directors of nursing ranged across ‘commitment’ (to the aims of the regulators); ‘capitulation’ (doing only what is necessary to demonstrate compliance); ‘resistance’; ‘disengagement’ and ‘game-playing’ (semantic argument or similar) (J. Braithwaite, Makkai, & Braithwaite, 2007, p. 291).

2.6.2 THE SHAPE OF A FIELD OF POWER RELATIONS

To more effectively approach analysis of the generative effect within a field of governmentality, it would be useful to move investigation out from a model, or at least, a shape or pattern, of power relations within the domain of interest.

The shape of power relations within an actor dyad

As discussed in the previous sub-section, Foucault was distinctive on the symbiosis of power and freedom. This suggests a characterisation of power relations in dyadic terms of domination and resistance. But Foucault is merely distinguishing between the exercise of power on the one hand, and a dynamic response on the other. Rather than a dead system of despatch and receipt, he sees power as “bringing out the freedom of the subject and its relationship to others” generating “several kinds of conduct, several ways of reacting” (Foucault, 2003a, p. 41). Thus, Foucault envisions a form of directed energy at both ends of the power relationship—that is, not only by the governing actor expressing power but also by the responding subject. This multi-directional characteristic is explicitly acknowledged by Foucault:

> It is certain that the mechanisms of subjection cannot be studied outside their relation to the mechanisms of exploitation and domination. But they do not merely constitute the “terminal” to more fundamental mechanisms. They entertain complex and circular relationship with other forms [emphasis added].

(Foucault, 2003d, p. 131)

The circulation of power

The circularity of power relations, as suggested by Foucault in this quote, is an attractive alternative to the familiar dyadic power and resistance narrative, and will apply in many instances (e.g. you pinch me, I tell the teacher, you get detention). But it is an incomplete conceptualisation. The regulatee’s responses in practice may not be directed within the strong guy/weak guy dyad at all, but within—to the regulatee’s self (e.g. I deserve to be
bullied)—or perhaps externally, to other actors (e.g. you pinch me, I pinch Harriet). Furthermore, it may be impossible to distinguish such a ‘response’ from an independent vector of influence directed at another actor. The shape of expressions of power and response begin to look more like a tangled web than a circle.

**Power in a web: the notion of assemblage**

The entanglement of patterns of power within a field of power relations is a problem recognised and developed by Newman and Clarke (2009) who argue away from dyadic unidirectional or even circular relations towards the more de-constructed notion of ‘assemblage’.

> Analysing governance as an assemblage...suggests ways of making visible some of the material consequences for those implicated in the process of governing. It also makes visible the moments at which users/citizens/residents refuse the places or roles they are allocated or at least refuse to perform them according to dominant scripts.

*(Newman & Clarke, 2009, p. 79)*

In this thesis, I adopt Newman and Clarke’s model of assemblage, following from the notion of entanglement, to assist in understanding the shape of a field of power relations.

### 2.6.3 OTHER SPECIFIC ANALYTIC FOCII

In mapping the analytics of government in the domain of present interest, particular features of generative relations within and between assemblages will be afforded particular empirical attention. These include the ingenuousness of governmental rationalities, and the flow of governmentality between assemblages of power relations generated from the subject’s freedom in response.

**Looking for Dean’s ‘inconvenient facts’**

In the first of these, the task is to assess for congruence between the web of strategy and practice enlivened by particular rationalities on the one hand, and the ostensible logic of those rationalities on the other. As Dean (2009) suggests, dissonance here suggests that the truth power of a rationality is being co-opted by the influencer for purposes other than the one suggested in the textual logic of the rationality.

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7 Harriet, certainly, may not be able to tell!
Dissonance between programme and response
As noted previously, the Foucauldian productive power-freedom agonism (Foucault, 2003a) envisages a subject who is no mere empty vessel waiting to be filled with a governor’s rationality (McKee, 2009). Although it is possible that a subject’s action in response might be compliant, subjects—in their freedom—have latitude within which to choose an alternative response, representing a form of resistance to being governed ‘like that’ (V. Braithwaite, Braithwaite, Gibson, & Makkai, 1994; Foucault, 2003a). The response, therefore, represents a new expression of governmentality, founding either the genesis of an assemblage with a new set of players, or a new direction and form for expression of power relations within an existing assemblage. It will have a truth claim or moral basis—a rationality—of its own, and represent some level of re-problematisation or alternative problematisation.

‘Governmental flow’: in the formation of alternative rationalities
The justification for a subject’s alternative-to-programme response has been described by Lippert and Stenson (2010) as a ‘lower rationality’ that may represent a nascent, alternative hegemonic rationality. This suggestion of a hierarchy of rationalities tends, in my view, to continue to privilege the state in the conceptualisation of governmentality. Alternatively, there is a body of literature detailing governmental power that is less about top-to-bottom transfer, and more suggestive of a flow of governmental process from actor to actor. Yes, the state makes policy and intervenes governmental. But then “as rubber meets road in local context” (Fairbanks II, 2008, para. 6), there is a possible instance of re-problematisation at every interstice of intervention and subject. New or adjusted rationalities of resistant, responding subjects fuel new vectors of influence which are either turned inward, back at the influencer, or hurtle off in new directions. Examples abound, like Lipsky’s (1980) street level bureaucrats; Stenson’s (2008) soft-tactics police in the Thames Valley who subvert the prevailing, zero-tolerance, political rationality (Stenson, 2008); McKee’s (2010) public housing tenants who are less-than-enthusiastic about being ‘empowered’, and Barnes and Prior’s (2009) ‘subversive’ citizens.

It is not acceptable, in my view (unless the specific task is to map change in state-generated rationalities), for a governmentality study to consider the productive effect of the rationalities of all relevant actors as other than of equal interest. A resistant responding subject generating a new vector of influence is not exercising an alternative rationality of any lesser value or interest than the dominant rationality (although it may have less impact). They are simply exercising governmental power.
The unification of subject response with the subject’s re-problematisation, re-rationalisation, and re-casting in the role of a would-be governor is a genealogical artefact characterising the movement of power within and across assemblages. It will be termed ‘governmental flow’ in this thesis.9

‘Governmental flow’: in the advancement of existing rationalities
But a subject’s response is not necessarily resistant. Like Braithwaite’s (2007) commitment-style nursing home directors, a subject, in their freedom, may choose a compliant response to a vector of influence. In compliance, the rationality of the would-be governor is accepted and adopted by the subject. In this alternative expression of governmental flow, the subject-turned-governor re-engages and promulgates that rationality in new expressions of influence in assemblages involving other stakeholders.

The second specific analytic focus of this thesis, then, is to discern the productive power of a subject’s response — in either re-definition or proselytism of the would-be influencer’s original problematisation — to identify instantiations of ‘governmental flow’ within the assemblages studied.

2.6.4 RESEARCH QUESTIONS AND LIMITATIONS

A limited scope for this Phase III sub-study
The problematisation for the overall mental health law and access project requires particular attention to the identification of effects resonating in access that arise from the deployment of the mental health law regulatory technology. To cover-off this investigation completely, the Phase II study should, ostensibly, address power relations between all stakeholder members of the mental health law and access domain. As explained in Phase I Scoping, however, the practical constraints of this PhD candidature require a more limited approach. Accordingly, the Phase III sub-study will address only the dyads of stakeholders that involve public psychiatrists either as subject or influencer.

Assemblages of interest
There are three primary assemblages reflecting relations between public psychiatrists and

8 For more discussion of governmental flow, see section
4.3 Governmental flow in assemblages supra.
each of the other three stakeholders in the relevant domain. Each primary assemblage has an a. and b. version, reflecting the psychiatrist and the second stakeholder each as influencer and subject. Thus, the assemblages addressed in the Phase III sub-study are:

- Assemblage 1: The State and (public) Psychiatrists (A1a and A1b)
- Assemblage 2: Psychiatrists and Consumers (A2a and A2b)
- Assemblage 3: The Community and Psychiatrists (A3a and A3b)

Principal and preliminary research questions
These practical limitations require a narrower research focus for the Phase III sub-study. Thus, the revised principal research questions for Phase III are:

- How is risk-based mental health law deployed within assemblages of power relations involving public psychiatrists?
- How does this functioning affect access to service?

These questions are circumscribed by the technology of mental health law and the access effect. But realising answers for them, with allowance for surprises, and for more finely-tuned analysis within the complex web of relations within the domain, requires a broader initial frame of enquiry. Accordingly, the method for the Phase III sub-study will additionally address the following preliminary questions:

- What are the operative problematisations, rationalities, strategies (including vectors of influence) and technologies of power in each relevant assemblage?
- What objectives of the influencer are inferred from the operative strategies and technologies? How do these compare with expressed rationalities?
- How do vectors of influence affect the action generated by the subject? On themselves? On other stakeholders in the domain? How does this action relate to the intentions of the influencer?

2.6.5 METHOD CHOICE

In this next sub-section, I look to the choice of methods to investigate the operation of an assemblage of power relations in the field, using a governmentality lens.

Criteria for method choice
In applying the governmentality lens to an actual or proposed regulatory intervention, it is
important that the method have capacity to reveal the practice and effects of the policy in time and place, and to enable inference of the elements of governmental assemblage.

**Directions from Foucault?**

Foucault took care not to prescribe any particular method, perhaps concerned to “resist the closure that systematisation brings” (Bracken et al., 2012). His followers, too, “[have strived] to avoid the ‘positivist’ trap of essentialising the research method” (Harwood, 2000, p. 59). Linda Graham describes the practical conundrum implicit in reporting on the use of governmentality in research methodology:

> Does this mean in the current…research climate beset by questions of ‘quality’ and ‘rigour’…that researchers of a post-persuasion must resign to playing…research according to the quasi-scientific rules of others?… On the other hand, to avoid my work being considered un-Foucauldian, must I be ambiguous?

*(Graham, 2011, p. 669)*

In this thesis, and like Graham, I have been unambiguous about my choice of methods and the composition of a governmentality conceptual frame, whilst continuing to strive to avoid positivism, and to respectfully engage with governmentality scholarship (Graham, 2011).

**Method alternatives**

A realist governmentality analytic could potentially engage any qualitative method that addresses human behaviour in context with capacity for interpretation. Eligible qualitative methods with interpretive capacity include discourse analysis, constructivist forms of hermeneutic enquiry and grounded theory, and the various ethnographic methods.⁹

It is instructive to regard the methods used by the growing body of realist governmentality scholars—in what Marston and McDonald refer to as “the re-emerging genre of ‘street-level’ policy evaluation” (Marston & McDonald, 2006, p. 7). Rather than dealing abstractly in concepts of power and resistance, realist governmentality scholars are interested in the practice of government, in the broadest sense, but as applied in the most intimate of local contexts.

Most frequently, they engage ethnographic methods (including interviews, focus groups, participant observation and case study) (Li, 2008; McKee, 2009, 2011a, 2011b;...

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⁹ Pure phenomenological or classical grounded theory methods would not be appropriate because of their positivist mission to re-constitute experience in terms as close to the informant’s perceptions as possible.
Newman & Clarke, 2009; Stenson, 2005, 2008). Ethnographic methods have capacity for “fine-grained, situated analysis [of the] shared emotional and cognitive dispositions of the everyday” (Fairbanks II, 2008, para. 3), as well as interpretive capacity. Kim McKee refers to the capacity of ethnography to “show how policies are implemented, expose their material effects, and reveal their unforeseen and unintended consequences, as well as their outward limits” (McKee, 2009, p. 479), as well as capacity to display “geographies of power and the way in which complex entanglements of power play themselves out in different places in different ways” (McKee, 2011a, p. 15).

In view of the synergy of these characteristics with the Phase III research focus, the methods engaged in “ethnography of government” (McKee, 2011b, p. 2) as employed by senior, realist governmentality scholars, are employed in the Phase III Governmentality sub-study. It is intended these methods will be applied through the lens of a governmentality conceptual framework that specifically seeks to identify the effects at the interface of the various assemblage elements and in the process of governmental flow.

The influence of grounded theory methodology will be apparent in the description of fieldwork to follow, particularly in the section on analysis. An influential approach to the development of theory about social phenomena, grounded theory was commenced with decidedly positivist orientation by Glaser (1978), with later more social constructivist directions sponsored by Strauss and Corbin (2008), Charmaz (2003) and others. I do not purport to be ‘doing grounded theory’ in the work described in this thesis but rather borrowing useful elements of the approach. The interpolation of governmentality conceptualisation at a point in the theory development process in the present method is not entirely compatible with the classical grounded theory expectation that theory should develop from data unfettered by external abstractions (Glaser, 1992), and the respective epistemologies differ.

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10 “[E]thnography decodes and recodes” (Clifford & Marcus, 1986, p. 2)
2.6.6 ETHNOGRAPHIC METHOD

What is the essence of ‘ethnographic method’?
In its traditional anthropological form, ‘ethnography’ involved long periods living with and observing a particular group of people under study. Other less-saturated ethnographic methods have since been employed widely across the social sciences, still with the aim of revealing patterns of difference and similarity of meaning and significance in ways of life (Denzin, 1997). These methods include historical analysis, discourse analysis, semi-structured and key informant interviews, and various group processes (Fetterman, 2010).

Macgilchrist et al describe what is common to the application of ethnographic methods across the social sciences: “Ethnography is concerned with understanding and describing meaning in social life” (Macgilchrist & Van Hout, 2011, p. 1). They suggest that, ideally, there is:

- ‘thick participation’, referring to involvement with the subjects of research in the field;
- ‘thick description’, referring to making a form of record of complex social activity; and
- ‘thick analysis’ which captures the use of multiple strategies of analysis on the materials which have been gathered.

It is clear then that ethnographic methods are appropriate to provide a window to the everyday world (Fetterman, 2010) of the public psychiatrists in their engagement with risk-based mental health law.11

Ethnographic discourse analysis
But the research questions also require functionality for discourse analysis, because of the importance within them of mental health law, a form of legal discourse comprehensively laced with rationalities12. Finding answers to the research questions requires looking both behind the rationalities—to their relation with the state’s intent—and ‘in front’ of them (genealogically-speaking), to the effects on subjects of vectors of influence powered by them:

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11 I distinguish between ethnographic methods, being methods used to discover meaning in social practice, and the conduct of ethnography, as it not my intention to identify or present a full picture of the working life of the public psychiatrist in Australia.

12 See sub-section 4.2.3 Rationalities of mental health law for a full discussion.
It is a question of analyzing a “regime of practices”—practices being understood as places where what is said and what is done, rules imposed and reasons given, the planned and the taken-for-granted, meet and interconnect.

(Foucault, 2003c, p. 248)

There is necessity, then, for the chosen method to be able to analyse legal discourse, other forms of written discourse, oral discourse, and everyday practice in the world of the public psychiatrist, through an ‘analytic of government’, the governmentality lens.

Usefully, there is growing interest in the integration of ethnographic and discourse analysis research methods (Macgilchrist & Van Hout, 2011). As talk is a social practice, the methods are clearly appropriate for the analysis of forms of talk (Clifford & Marcus, 1986), including power-productive forms of talk, as well as for identifying the conditions and practices generating and generated by that talk. The existing realist governmentality studies all utilise a form of discourse analysis, often as their principal tool (Li, 2008; McKee, 2009, 2011a, 2011b; Newman & Clarke, 2009; Stenson, 2005, 2008).

In the mixed-model study, discourse analysis is engaged but as a method subsidiary to the ethnographic field methods.

Field methods employed
The field methods for the Phase II Realist governmentality study utilise a semi-structured interview method with transcribed audio recording to permit the necessary ‘thick description’ and situated analysis. Additionally, a form of discourse analysis is conducted on the mental health law and other relevant policy documentation. The results of both are analysed together through the realist governmentality analytic framework, as previously described.

2.6.7 SAMPLING

Sampling frame
The sampling frame for the study included participants who:

- were either fully qualified medical specialists in psychiatry or psychiatrists-in-training;
- had current or recent (within two years) work in a public mental health facility;
- worked in a metropolitan location;
- did not practice exclusively in forensic psychiatry, and
- responded positively to an invitation to participate.

**Sampling**

To commence the process of collection of informant accounts, I wrote to obtain the sanction and assistance of the Research Committee of the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

The RANZCP circulated my invitational text, along with its endorsement of the research, to its state and territory chapter offices. After consultation with all the individual chapters, three of them published the invitational text in their respective monthly newsletters.

The invitational text was deliberately broadly and neutrally termed, noting only that the study was intended to “address the practical outcomes of clinicians’ engagement with mental health law”. Clinicians interested in participating were invited to contact me directly. Only a handful of participants contacted me after this initial set of steps.

**From snowball to purposive sampling**

My next strategy involved leverage of the influence of senior clinicians known to me in all of the Australian jurisdictions. These practitioners were asked to recommend participation in the study to other eligible practitioners of their acquaintance. Many more interviews were arranged. As interviews progressed, other participants were acquired through the recommendation of earlier participants. I contend that the potentially corrupting effect of personal contact in these snowball methods was mitigated by the use of the neutral and standardised invitational text, and standardised ‘participant information’ forwarded to potential participants upon first contact.

Initially, I proceeded to conduct interviews with all willing participants within the sampling frame, as it appeared the overall number would not be large. Over time, however, as the new methods of contacting members were used and became productive, I employed more purposive criteria. I sought a range of views across seniority, gender, role, practice context and across a minimum of four state or territory mental health law jurisdictions.

I continued to conduct sampling on this basis until the thrust of the data became clear in each of the specific areas of interest under study, reflecting Dey’s principle of sufficiency (Dey, 1999). In total, 28 psychiatrists were interviewed.

Table 3 illustrates the demographic and geographic characteristics of the sample of informants. I submit that, for the small sample size, the mix represents a sufficient
interrogation of the views of the population in the context of unfunded, solo doctoral study. Furthermore, the data required and obtained was substantial in volume and rich. It required a fine-grained analysis that would not have been practical with a larger group.

Notwithstanding that the study did not aim for statistical representativeness of the population of Australian and New Zealand psychiatrists, the demographics of the sample as a whole approximates the relativity within the principal demographic variables of the population as a whole, in gender, age, professional and jurisdictional spread (Royal Australian and New Zealand College of Psychiatrists, 2012) so far as these can be ascertained.
Table 3
Phase III sub-study: Sample demography.

<table>
<thead>
<tr>
<th>Total n=28</th>
<th>n</th>
<th>% of total(^{13})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>18</td>
<td>64</td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>36</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-40</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>41-55</td>
<td>14</td>
<td>50</td>
</tr>
<tr>
<td>56+</td>
<td>8</td>
<td>29</td>
</tr>
<tr>
<td>Professional role</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant psychiatrist</td>
<td>15</td>
<td>54</td>
</tr>
<tr>
<td>Manager</td>
<td>9</td>
<td>32</td>
</tr>
<tr>
<td>Registrar (psychiatrist-in-training)</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Practice context</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>19</td>
<td>68</td>
</tr>
<tr>
<td>Community-based service</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Older persons psychiatry</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Crisis team</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>10</td>
<td>36</td>
</tr>
<tr>
<td>VIC</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>SA</td>
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<td>11</td>
</tr>
<tr>
<td>ACT</td>
<td>10</td>
<td>36</td>
</tr>
<tr>
<td>TAS</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

2.6.8 PRE-INTERVIEW PROCESSES

Upon verifying eligibility in relation to the sampling frame criteria, each confirmed participant was sent an Information Sheet and an Interview Consent form. Both the Information Sheet and the Interview Consent Form were approved by the ANU Human

\(^{13}\) Rounded to the nearest percentile.
Ethics Committee, as was the recruitment method.

At the beginning of each interview, I referred again to the Information Sheet and, in the majority of cases, needed to attend to the participant’s signing of the Consent Form. I reminded participants that the interviews would be recorded, transcribed, de-identified, analysed. I encouraged participants to describe practice they saw around them, rather than their own practice, if they felt more comfortable doing this.

In the course of the interviews, there were no expressions of surprise or concern about the direction of the discussion, notwithstanding its frequent sensitivity relating to the day-to-day practices of self and others in relation to the law. I consider, then, that the preparatory information was well-gauged.

2.6.9 INTERVIEW DESIGN

Four heads of functionality
The requirement for rigour in design of the interview required that sufficient scope be provided to allow for data on different types of engagement with mental health law, and their access effects, to emerge from the totality of practice—rather than to target its expression in pre-figured forms. Accordingly, the interview was structured around four specific sub-heads of psychiatrist functionality: identifying treatment pathways; managing resources; delivering clinical services, and protecting against adverse events. The aim was to identify the action of power relations within each, with broad open-ended questioning and discussion prompts, but with enough structure to enable comparisons and to stay ‘on-topic’ in relation to use of the law and access.

Other criteria
I considered also that the quality of the data would be greatly enhanced if clinicians enjoyed and felt relaxed during their informant experience. This required that the material should be intellectually stimulating, that I should establish rapport, and that I could convey that this was an opportunity to be heard on these matters very close to their sense of professional satisfaction and identity, to provide an opportunity for unburdening (if this was desired), and to enable the clinician to arrive at, and centre on, hot button issues of particular interest to him or her.

92.
Stimulus material
The interview was structured, then, with some direct questions but also with one- or two-paragraph discussion pieces of academic literature relevant to the research questions and to one or more of the four functional sub-heads. These prompts were shown to the participants for the first time only in the course of the interview. See Appendix A for the text of stimulus material provided. Participants were asked to respond to the stimulus material—about whether they agreed or disagreed with the views expressed in the piece, or about whether their practice, or the practice they saw around them, coincided with those described in the stimulus piece. It was clear that participants often found it difficult to formulate responses they were happy with, without more time to consider. This slight discomfort at being less articulate than their norm, seemed, at the same time, to be intellectually enjoyable for the majority. As researcher, I felt excited to have access to fresh, relatively unfiltered data.

Refining the interview script
The initial interview design was tested in two pilot interviewees with psychiatrists from my local academic reference group. After these, I reduced the number of questions overall for better fit within the one-hour format.

I also removed an early question that referred the clinician to a written section of the local mental health law. This seemed to elucidate stress from participants, suggesting the need to demonstrate an appropriate grasp of the relevant law, which many of them clearly did not possess. It also highlighted differences between myself, a lawyer, and their ‘doctor selves’. Generating insecurity and highlighting difference did not seem to be a productive way to commence an interview.

2.6.10 CONDUCT OF THE INTERVIEWS

Physical arrangements
Arrangements were made with 25 of the participant psychiatrists or psychiatrists-in-training “at a place and time convenient to them”. I travelled on three occasions to Sydney, New South Wales, once to Melbourne, Victoria and once to Adelaide, South Australia to conduct interviews with participants in those locations. In all cases of physical interview, these were conducted at the participant’s workplace. Upon arrival, and across the period of introductory chat, I set up a small field-study audio recorder and microphone in an
inconspicuous location (in most cases).

Three participants were interviewed by telephone. The audio for these interviews was recorded from speaker-phone output. Interviews of two other participants took place in the absence of audio equipment.

I interviewed all participants for between 50 and 90 minutes. Audio records of 19 of the 28 interviews were successfully made.

Due to operator error on my part, an audio record of seven consecutive interviews was not successfully made. I discovered this within three hours of completion of this set of interviews. I then re-created very detailed notes of interview immediately. Notes of interview were created after the conclusion of each of two unrecorded interviews also. Had the data from these nine interviewees been excluded, the demographic mix of the sample would not have substantially altered (from the proportions set out in the demographic elements of Table 3). As seven of the ‘noted’ interviews took place in NSW, and the two unrecorded interviews in the ACT, the geographic balance of informants across jurisdictions would have slightly improved.

The informant’s experience
It was my impression that the majority, if not all, of the participants positively enjoyed their experience of participation in the study. They were comfortable in the interview environment, they enjoyed de-briefing about what disturbed them about certain practices they saw around them and sometimes felt compelled, themselves, to engage in. They enjoyed reflecting on why they did what they did, and finding words to express their decided approach to dealing with outstandingly difficult, day-to-day workplace issues. They found it surprising that their views on such matters should be sought and recorded, whilst feeling, at the same time, that what they had to say should be heard. Several expressed their thanks to me—for raising these “very important” issues and for asking their views about them—some in quite affecting, personal terms.

2.6.11 TRANSCRIPTION

Audio records of interviews were downloaded from the audio device and forwarded electronically to a transcription service based in South Africa on a progressive basis. Transcriptions were returned electronically as files in Microsoft ‘Word’ format. The quality
of transcription was good, considering the speed of the speech of some participants, their use of technical and advanced vocabulary, and the transcriber’s lack of cultural familiarity with place names, systems and processes. But it was necessary for me to check all transcriptions against the original audio recording to fix inaccuracies. This did assist, however, in the quality of my analysis.

The transcriptions and the interview notes were uploaded into an NVivo 10 database. NVivo (Version 10.0.138.0, 2012) is qualitative research support software (Gibbs, 2002).

2.6.12 ANALYSIS

Accounts generated from the psychiatrist interviews were subjected to thematic analysis and, also, to a separate governmentality-inspired analytic. Coding in both analytic modes was undertaken with the assistance of NVivo 10.

Open coding
Coding, unfortunately, did not commence until near to the conclusion of interviews because of the slow return rate by the transcriber.

Transcripts and field notes of interview were imported into the NVivo database and ‘attribute’ or descriptive information about each informant collated. The attributes tracked included: gender, age range (25-40, 41-55, 56 and over), professional role (consultant, manager, registrar), service context (community-based, hospital, older persons psych unit, crisis team), and jurisdiction (NSW, VIC, ACT, TAS, SA).

Analysis proceeded by the breaking-up of the text of interview transcript or field notes into small portions of text to which were allocated ‘open codes’ (a meaning label for the material within the reference) (Charmaz, 2003; Hutchison, Johnston, & Breckon, 2011). Four informant interviews were initially coded in this fashion, generating what seemed, at the time, a vast number of open codes (really only about 150). It was useful, however, to proceed with open coding to this point, where there seemed altogether too much data to support any pre-conceptions about its likely direction.

Commencing thematic coding
I took a break then from work with the transcripts to commence formal thematic analysis. This involved a fresh approach to the open codes, grouping existing open codes into a group of conceptual categories, called ‘tree nodes’. This process was analogous with the grounded
theory process of developing core categories (Glaser, 1992). As it continued, a second level of categories developed within the first level of nodes, similar to the process of axial coding advocated by grounded theorists Strauss and Corbin (2008).

After an initial grouping of most of the original codes into tree nodes, I returned to open-coding new sources. After open-coding another set of three sources, I tidied open codes into existing, new and amended tree nodes. This iterative process of open, followed by axial, coding proceeded until completion of coding of the text of the ninth informant account.

Commencing the governmentality analytic
My initial intention had been to conduct a thematic analysis in the hope that the governmentality theoretical elements would either emerge in due course, or be derived from the thematic groupings in a second process. It became clear, however, that the quantity of data was too great to permit informal emergence and that, in any case, the developing descriptive architecture within the thematic trees inhibited, rather than encouraged, such emergence. In short, I had begun to regret a missed opportunity for performance of the governmental analytic from fresh, unclustered open codes.

As the thematic analysis was intended, methodologically, to support rather than thwart the analytic of government, I decided to commence the governmental analytic more formally, introducing additional tree nodes representing the assemblages involving the three relevant dyads of actors (as identified infra at section 2.6.4 Research questions and limitations). In each tree, there were sub-nodes identified by elements of governmentality assemblage: ‘rationale’, ‘objective’, ‘strategy’, ‘technologies of power’, ‘informant ‘action-on-the-self’ and ‘action externally’. These remained in place, for the duration of the analysis, as empty place-holders until, and if, open codes arose from the data to fill them.

I also re-examined each open code from each of the first nine source texts. I did not delete or move them from the thematic trees but often copied the existing open codes into the governmentality trees. This re-coding was a lengthy but valuable process.

After the completion of re-coding of the original nine, I re-started the iterative process of open-coding of new sources, followed by thematic, and now, also, governmentality coding, for one or two account texts at a time.

Transferring focus to the governmentality analytic
At transcript number 12, I recognised that there was too much multiple coding of single
pieces of text. I reviewed the thematic codes and now could see significant overlap with the
governmentality codes. Again I took a break from open-coding and broke apart all of the
existing thematic tree nodes, folding relevant open-codes into the governmentality structure,
eliminating duplicates.

There remained a number of thematic trees but far fewer. There was an amount of
thematic material that seemed important to code, and to keep, because it did genuinely arise
strongly from the data, despite that its place within the schema of governmentality elements
was not clear. These included a collection of policy change suggestions made by many
psychiatrists, and sets of reflections on the workings and adequacy of aspects of mental
health law and the mental health services system.

A second problem of duplication…or analytic insight?
Very shortly after re-commencing coding from new sources, the workability of the newly-
weighty governmentality trees started to generate concern. Though now seeking to avoid
theoretic code duplication, I saw that the same reference could be appropriately represented,
within the various assemblage trees, in more than one place. For example, the account of a
practice representing an action-in-response of a subject in one assemblage might also
appropriate be indicative of a technology of power in another. Although identifying such a
relationship was theoretically informative, and illustrative of one of the special focii for
analysis (governmental flow), it was difficult to represent without again spawning multiple
codes.

There were a number of such congruences. They represented, for the most part,
specific regimes of practice of the psychiatric clinician in relation to mental health law that
had resonance in access to service. Recognising particular theoretical importance, and again
seeking to minimise duplication, I decided to take these practices into separate theoretical
nodes of their own, whilst marking their relevance and location through empty place-holder
nodes within the primary assemblage code architecture. The iterative process of open
coding, paralleled with thematic and governmental coding, continued then until all source
texts had been coded.

Continual refinement
At the conclusion of the initial coding of all source texts, the process of refinement of
theoretical coding progressed. There was constant reflection on the relevance for
thematically-coded material within the assemblage coding structure, and deep focus on the
meaning of references in governmentality terms. By this process, for example, most of the
references stored in the thematic ‘responsibility’ code found a place within the theoretical
governmentality assemblage nodes. This occurred after recognition that discourse about
‘responsibility’ functioned within a number of assemblages as a rationality generating
technologies of power that re-located, or attempted to re-locate, blame for adverse events.

Literature review
The depth of analysis in relation to formal and informal means of rationing scarce health
resources was advanced by a circumscribed return to the literature. This enlightened my
interpretation of the large number of references in interviews to practices related to triage in
the scarce resource environment in which almost all informants performed their work.

Memoranda
During the interview process and parallel to the coding process, I had been writing
memoranda. I wrote in ‘Reflections Memo’ after most of the interviews; a running ‘Project
Memo’, essentially a project management journal; and a ‘Literature Memo’ which
summarised salient points and thoughts about a small number of items of literature reviewed
mid-analysis. In ‘Total Ideas Memo’, I reflected on thematic and theoretical development
during the analysis process. At a later point in this memo, I wrote within-tree and across-
tree narratives, integrating the coded material. This process ultimately led to the formation
of the thematic constructs and the governmental genealogy that would constitute the results
of the study. All memos were eventually coded, generating a number of new ancillary (to
theory) trees.

Final stages of analysis
At the third coding benchmark before the end of the process, the coding structure for the
study represented six separate tree nodes: aspects of methodology; primary themes
(descriptive); the set of assemblages (governmentality); the set of theoretic ‘assemblage
extrusions’ (governmentality); a set of psychiatrist’ views on the problematisation of mental
health law and access (descriptive); and a miscellaneous tree (descriptive).

The principal results of the study—by reference to the research questions—would
be determined by synthesis of the primary themes tree node, the assemblage tree node, and
its helpful extrusion of law- and access-related elements. I returned to literature at this point
to ensure my understanding of realist governmentality analysis.

The final stage of theory development involved the formation of synthetic constructs
and genealogical narrative that explained the involvement of mental health law within the
governmentality assemblage studied, and how, from study of the particular regimes of
practice highlighted in the study, it generated effects on access to mental health services.

**In relation to internal methodological rigour**

The analysis of the Phase III mental health law and access governmentality study was undertaken in the absence of existing strictures about ‘how to’ perform a realist governmentality analytic, and involved some trial and error. It is submitted, however, that it was performed with sufficient methodological rigour, supported by the explication of elements of the analytic of government present in the literature, the engagement of grounded theory values such as iterative process, direct coding from wide-ranging ‘thick description’, and constant focus on progressive, theoretical development (Hutchison et al., 2011).

### 2.6.13 LEGAL DISCOURSE ANALYSIS

The discourses identified as the most important for analysis were the mental health laws applying in the five Australian jurisdictions in which the psychiatrist informants worked (“the Phase III jurisdictions”).

The relevant laws were:

- *Mental Health Act 2007* (NSW)
- *Mental Health Act 2014* (Victoria)
- *Mental Health Act 2013* (Tasmania)
- *Mental Health Act 2009* (SA) and
- *Mental Health (Treatment and Care) Act 1994* (ACT)

These laws were analysed at an individual and then at a group level.

There were three specific foci of the legal discourse analysis: the role of risk-oriented regulatory technologies within the law; the content of the ‘Objects’ clauses (which sets out the state’s political rationality for the law as a whole); and an examination of the content of the balance of the law, in relation to its ostensible purposes.

Additionally, I examined policy and clinical practice documentation, and academic literature for each of the five Phase III jurisdictions, and federally, in the following three areas, seeking further explication of the rationalities of the state in relation to risk management and access to service:
- clinical practice guidelines (such as clinical risk assessment and management codes of practice, and suicide risk and management protocols);
- mental health policy statements, and
- triage guidelines.

The discourse analysed was coded into the governmentality assemblage node tree within NVivo, thus integrating the product of the discourse analysis with the ethnographic analysis.

### 2.6.14 Reflexivity

In this section, I reflect on my own biographical, psychological, academic and philosophical positioning and its effects in relation to the governmentality sub-study. I also describe the reflexive elements of the research process.

**Biographical and psychological**

As an older-than-usual, Anglo, female PhD student, I was positioned homogenously with the participants of the study, in which a little less than half were women, several older and younger than 50 and all, but one, of an Anglo ethnic background. Further, and like the study participants, I have a profession. I am a lawyer and a dispute resolution practitioner by training, and have pursued consulting, and community-based legal and social justice projects in my career. These characteristics enabled me to relate reasonably effectively, more-or-less as a peer, with most informants.

An effort to maintain a conscious poise on my part kept my focus on establishment and maintenance of appropriate distance between myself and the informant for the most part of the majority of interviews, to the extent that this could be consciously managed.

But the interviews were not designed to account for the considerable empathy I felt for the informants. It is only retrospectively that I see that my apparent empathy likely encouraged the provision of account material that would elicit more of that response. As the data obtained was in line with the aims of the study, there is no need to attempt to bracket-out this effect but rather to note that researcher empathy likely did form part of the construction of these types of accounts.

**Ontology**

I came to this PhD candidature with a particular, problematised interest in the effect of
mental health law on access, after several years as a consultant in an Australian jurisdiction’s mental health law review. I came also with the strongly normative aims of a policy consultant: what would constitute ‘good’ or at least ‘better’ regulatory governance in this domain. Much like the methodology of this thesis, I am at once critical, interested in the minutiae of social practice, and yet interested in what might constitute a global, ‘win-win solution’.

Apparently one of White’s ‘weak ontologists’, I agree that “all conceptualisations of self, other and the world are contestable” (White, 2000, p. 8) but that, at the same time, the formation of conceptualisations and the making of interpretations is unavoidable:

…a critical post-structuralist approach need not be anathema to the making of claims, nor should it be seen as suffering from a paralytic disjuncture from the “real world”… Hence, maintaining critical commitments can mean being reflexive about the indeterminacy of the claims that are ultimately made while being accountable to them.

(Mustapha, 2013, p. 64)

This position aligns with other views about the value of holding interpretive and genealogical perspectives in productive disharmony, whilst acknowledging that they cannot be wholly reconciled. Ferguson (1991), for example, notes that the two approaches have important linkages, including that genealogy must start and at some point cease, within interpretation, because that is all that is possible:

Genealogy…is dependent on interpretation in order to have something to deconstruct. Beyond this, one follows the genealogical position to a return to interpretation. Because the world turns us no legible face, because nothing stands under the layers of constituted meaning except other layers of constituted meaning, one returns to interpretation with the fragile understanding that interpretation of various kinds is all that there is.

(Ferguson, 1991, p. 335)

Engaging this productive disharmony between interpretation and genealogy in the Phase III sub-study, the ‘constructing’ was comprised by my interpretive thematic analysis of the informant accounts (co-produced with me) in the content of interview texts, supplemented by discourse analysis data. The ‘de-constructing’ occurred in the course of governmental analytic. In the end, what the psychiatrists (and I) consider to be real about themselves, about the way the system operates, and the action of other stakeholders, may or may not be reflected in the final synthetic product describing the way power works within the system but is, nevertheless, its fundament.
2.6.15 CONFIRMABILITY

I have attempted, in the Phase III sub-study, to demonstrate academic rigour by addressing Morse’s (2008) criteria of investigator responsiveness and the engagement of within-study verification strategies as follows:

The methodology has described my responsiveness, as an investigator, to the several progressive challenges in the coding of data as these arose in the course of analysis.

I have outlined, also, the care taken to ensure methodological coherence, matching the problematisation of risk-based mental health law and access:

- with the research questions;
- with the theoretical base of governmentality;
- with the ethnographic methods employed, and
- with a combined grounded theory/genealogical approach to data analysis.

Sampling sufficiency has been addressed by the conduct of an adequate number of informant interviews, which generated sufficient data on core issues, and some negative cases.

Concurrent data collection and analysis occurred only across the period of the last five informant interviews, due to delay in commencement and receipt of transcriptions. I did, however, write memos, a form of analysis, in the course of the data collection process, and, as noted in the field method described above, made some amendments to the interview design as a result of the reflections contained in these.

I have striven also for well-developed theory development through ‘thick analysis’ (Macgilchrist & Van Hout, 2011) of the data, involving iteration between raw and theoretical coding. There was also analytic triangulation at two junctures. First, the initial thematic analysis of informant accounts was followed by the sensitive application of a governmentality analytic. This step was intended to anchor the interpretation implicit in the governmental analytic, by ensuring sufficient analytic material of the everyday. Secondly, there was synthesis of the interview data with the product of discourse analysis within the governmentality node trees. The governmentality node framework was not imposed, however, so as to drive the collection or categorisation of data ‘to fit’. There were several gaps in the genealogical maps of the relevant assemblages. Theory development did not proceed in these thinly-supported areas.
2.7 PHASE IV SYNTHESIS METHODOLOGY

In the following section of this thesis, I describe the methodology for the Phase IV Synthesis of the mixed-model study. I address, first, the nature of the synthesis undertaken, which, I argue, must be both integrative and interpretive. Lastly, I outline the intended process for conduct of the synthesis.

2.7.1 INTEGRATION AND INTERPRETATION

Developed from the systematic review methods, a new range of ‘meta-synthesis’ techniques, driven by the quest for best practice in policy-making, has been derived for review of quantitative, qualitative, and the so-called grey literatures, and for mixtures of some or all of these. Specialist scholars in meta-synthesis have been concerned to distinguish synthesis from a simple review of literature (Thorne et al., 2004), and as a process that is not merely integrative of the results of the studies synthesised (that is, finding the sum of all the parts, the ‘right’ way forward), but also interpretive (Dixon-Woods et al., 2005). In the words of Margarete Sandelowski:

Meta-syntheses are integrations that are more than the sum of parts, in that they offer novel interpretations of findings. These interpretations will not be found in any one research report but, rather, are inferences derived from taking all of the reports in a sample as a whole.

(Sandelowski in Thorne et al., 2004, p. 1358)

Similarly, meta-synthesis has been described as “going beyond” the component results (Britten et al., 2002, p. 210) to “grab the essence” (Jensen & Allen, 1996, p. 554) of understanding or interpretation of the phenomena to hand. The value of such an approach for development of mid-range theory—entailing a moderate level of abstraction and yet capable of implementation in practice or policy—has now been widely recognised (Dixon-Woods et al., 2005; Estabrooks, Field, & Morse, 1994; Greenhalgh & Peacock, 2005; Thorne et al., 2004).

The methodology for the Phase IV Synthesis of the mixed-model study engages principles of meta-synthesis, as will be described below. It invites not only a ‘knitting’ of the outcomes of network governance and realist governmentality sub-studies, but also a ‘go
beyond’ form of integration, generating a new level of interpretation or theory that aims to be more than the sum of its Phase II and Phase III sub-study parts.

2.7.2 POTENTIAL DIFFICULTY IN SYNTHESISING DIFFERENT APPROACHES

Early exponents of meta-synthesis expressed caution about the wisdom, indeed, of the possibility, of synthesising studies of different methodological approach. In this case, it was suggested, the process of synthesis, particularly in its integrative form, involves the attempted totalisation of understandings of the same phenomenon garnered from studies of irreconcilable epistemic and ontological orientation (Estabrooks et al., 1994; Jensen & Allen, 1996) resulting, not in true synthesis, but rather indeed a “quagmire” (Barbour, 1998, p. 352) or “metasoup” (Thorne et al., 2004, p. 1347).

On the other hand, there are arguments for the syntheses of methodologically-disparate studies that address these concerns. These include:

- that there are contributions to the confirmability of the whole of the conclusions arising from the methodological and theoretical triangulation contributed by the difference between the studies;
- that the process of meta-synthesis is a valuable step reflecting, and potentially directing, the true, collective, iterative nature of research; and
- that the employment of a number of different methodologies redeems for the inadequacies of any one (Barbour, 1998; Jensen & Allen, 1996).

My arguments for twinning the disparate methodological approaches of network governance and governmentality apply equally to possible objections to their ‘synthesize-ability’. First, the approaches—a relatively non-normative governance and a relatively realist governmentality approach—are not conceptually irreconcilable. Secondly, the Phase IV synthesis takes its orientation clearly within the critical realist paradigm of the overall project, which can integrate and value the located, subjective experience contributed by the governmentality sub-study. Thirdly, the different sub-studies address different aspects of the phenomenon of power relations, and the interdependence of interest groups, in a specific social policy domain. This is not what occurs in the attempted metasynthetic ‘quagmires’ of concern, in which the same phenomenon is studied from quite different perspectives.
Difference is not the death of the mixed-model framework but rather what gives it life and value for policy development. When the differences between the two studies are drawn together, and indeed celebrated in a final synthesis, the result represents not a ‘meta-soup’ but a satisfying three-course empirical meal that nourishes intelligent policy practice.

2.7.3 SYNTHESIS METHOD

The method employed for the Phase IV Synthesis was built from the principles of meta-synthesis developed in the academy over the last 15 years. The method employed has both integrative and interpretive outcomes.

Integration

The synthesis of Phase II and Phase III is necessarily integrative as each sub-study addresses quite different, and yet complementary, aspects of the interrelation of actors within the mental health law and access domain. To ‘tell the (integrated) story’ of the mental health law and access policy domain, the Phase IV synthesis employs the principles of meta-narrative as described by Greenhalgh et al. (2005). These are summarised in Table 4 below:

<table>
<thead>
<tr>
<th>Principle</th>
<th>Associated goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pragmatism</td>
<td>Accept the impossibility of true systematisation of multiple or heterogenous</td>
</tr>
<tr>
<td></td>
<td>literature. Make firm choices of threads to follow with a view to audience</td>
</tr>
<tr>
<td></td>
<td>and research focus. Find a plot.</td>
</tr>
<tr>
<td>Pluralism</td>
<td>Expose paradigmatic tensions and complexity.</td>
</tr>
<tr>
<td>Historicity</td>
<td>Retain a sense of time and place in story development.</td>
</tr>
<tr>
<td>Contestation</td>
<td>Unpack ‘incommensurabilities’ in data.</td>
</tr>
<tr>
<td>Peer review</td>
<td>Avoid problems of solo-think and group-think by review outside the project team.</td>
</tr>
</tbody>
</table>

Source: Greenhalgh et al, 2005.
Interpretation
The second task of synthesis, interpretation, requires the derivation of theoretic product that ‘goes beyond’ the conclusions reached in each of the component studies. The Phase IV synthesis method employs the structure of the widely-practised, though very intensive, meta-study method (B. L. Paterson et al., 2001). Meta-study encourages synthesis practice at three separate perspectives—data, method, and findings. This multi-perspective approach is employed in the Phase IV synthesis.

Additionally, when generating an interpretation at the ‘findings’ perspective, the Phase IV synthesis incorporates elements of the meta-ethnographic ‘lines of argument’ synthesis (Dixon-Woods et al., 2005; Dixon-Woods, Cavers, et al., 2006; Noblit & Hare, 1988).

Phase IV synthesis method
The full process of Phase IV synthesis as set out in Table 5 below incorporates features facilitating both the integration and interpretation of the twinned sub-studies in the mixed-model framework of analysis. It attends to recognised principles and processes of meta-synthesis, including meta-narrative review (following Greenhalgh), meta-study (following Paterson) and meta-ethnography (following Noblit and Hare). Leveraging the value of the difference between the network governance and realist governmentality approaches, the synthesis method is intended not only to enable a ‘portrait’ of the mental health law and access domain but to generate theory in relation to the principal research questions of the project as a whole, and to alternative policy directions.

<table>
<thead>
<tr>
<th>Element of analysis</th>
<th>Action undertaken</th>
<th>Associated method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theory</td>
<td>Consider how various theory frameworks shaped outcomes.</td>
<td>Meta-study</td>
</tr>
<tr>
<td>Method</td>
<td>Consider how various methods shaped data.</td>
<td>Meta-study</td>
</tr>
<tr>
<td>Findings</td>
<td>Find ‘the story’ of the data. Analyse using reciprocal translational and refutational processes. Build an interpretive synthetic argument.</td>
<td>Meta-narrative review Meta-ethnography</td>
</tr>
</tbody>
</table>

Adapted from Dixon-Woods (2005); Paterson et al. (2001) and Noblit and Hare (1988).
Regulatory reform, ‘renegotiation of regulatory space’, might then focus not exclusively, or even mainly, on a single organisation, but rather on the whole configuration of resources and relations within the regulatory space. Some capacities might be enhanced and some constrained.

(C. Scott, 2001, p. 330)

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3.1 INTRODUCTION

Research questions reprised

The research questions for the Phase II network governance sub-study were specified in Chapter 2 Methodology as follows:

- What are the relevant stakeholders’ interests, values, and culture?
- What factors affect each stakeholder’s capacity to influence outcomes in the domain in the direction of their interests?
- What is the regulatory capacity of each stakeholder relative to others in the domain?
- What is the salience of the interest ‘access’ relative to other operative interests within the domain?

Summary of method

To address these questions, I conducted a qualitative, literature-based study employing a version of the critical interpretive synthesis method modified for the conditions and purposes of this thesis.

Modifications included applying a filter, in sampling and data collection, based on the NATO model of regulatory capacity, with the added notion of ‘agenda identity’ (AI).

Synthesis involved the derivation of synthetic constructs and a principal synthetic argument characterising the NATO/AI for each of the four studied members of the mental health law and access domain: the community, consumers, public psychiatrists and the state.

A second and third process of synthesis, working with the synthetic constructs and argument per stakeholder, rated the regulatory capacity of each stakeholder and the salience of the access objective per stakeholder.

A final synthesis of these access ratings determined the final construct of the salience of the access objective across the domain.

Structure of this chapter

Findings and discussion are set out below for each of the four stakeholder types hypothesised for the mental health law and access domain.

For each stakeholder, the results of thematic analysis are first described, under headings for each of the major themes. At the end of each stakeholder section, the results of a ‘mini-synthesis’ of thematic results for that stakeholder are described, highlighting the
central synthetic construct and synthetic argument.

The overall synthesis products are set out in the final major sub-section to the Chapter. These include a summary of the synthesis relating to each stakeholder, an assessment of their relative regulatory capacities within the mental health law and access domain, and a final synthesis of results interpreting the salience of the access objective across the domain.
3.2 THE CONSUMER

3.2.1 NO POWER AT ALL?

The consumer's lack of power

A number of the sampled writers identify that consumers have little power within the mental health system (McCubbin & Cohen, 1999). Consumers were said to occupy “the bottom rung” in the hierarchy of power relations in the mental health sector (Stickley, 2006, p. 570). Alternatively, and as described by Kelly (2006), the phenomenon has been termed a “power gap”:

The persistent erosion of power and freedom experienced by individuals with mental illness has resulted in a significant ‘power gap’, whereby the needs of the mentally ill are grossly under-represented on both societal and political agenda. As a result, the rights of the mentally ill are persistently undermined by a collection of social and political arrangements that limit not only the extent of present freedoms but also the potential to achieve further freedoms through social and political systems.

(Kelly, 2006, p. 2124)

A range of reasons is proposed for the purported low level of influence of consumers. These include: the diffusion of political power among mental health interest groups; structural exclusion from the ordinary benefits of citizenship, such as employment and housing; the inability of consumers to recognise and argue for their own interests (Kelly, 2006); the lack of concern of voters (Wolff, 2002); the rise of evidence-based medicine (Essock et al., 2003); the larger society attributing moral responsibility to consumers for their own condition (Pustilnik, 2012), and even wider, political factors such as the health of the economy (Hernandez & Uggen, 2012).

But consumers find ways forward…

The intimation of an utter lack of power or influence on the part of consumers is countered by evidence in the data that consumers exercise counter-strategies to achieve their interests (Johansson, Skärsäter, & Danielson, 2006). McRae (2009) demonstrates how forensic patients manipulate test results to achieve more favourable forms of disposition through the system. Johansson et al. (2006) describes the strategic behaviour of consumers on a locked
ward. Long (2012) relates a social worker’s suggestion to the mother of a consumer, for whom she had tried and failed to obtain treatment, that the best thing she could do was to arrange for her son to be charged with a crime:

That’s the only way you’re ever going to get anything done. No one will pay attention to you unless you’ve got charges.

(Long, 2012, para. 29)

This anecdote echoes my own experience, during a public consultation forum in a mental health law review in 2007, where I heard a youth worker describe how his clients committed deliberate acts of criminal violence in order to ensure the support of police in gaining admission to the mental health unit at the hospital.

Non-compliance as form of resistance
The literature identifies that non-compliance can be an expression of power, albeit mostly expressed in resistant response to pressures exerted upon them by the balance of society. Johannsen (2009), for instance, hypothesises that the non-compliance she identified in the clinical setting may have been an expression of resistance to power difference, rather than genuine disagreement with a proposed course of therapy and treatment. This is echoed by Klassen (2011), who recognises that even engagement with a therapist can be experienced as a form of discipline. Indeed, it might be argued that compliance with chemical therapy, any form of compulsory treatment, and the surveillance and loss of freedom entailed in virtually any consumer experience in the public mental health system, is a form of discipline also.

Klassen is interested in the form of governance by which non-compliance is designated as tantamount to incompetence, for the purposes of creating a consumer-subject who makes the ‘good choice’ to comply with treatment recommendations. Following from this, we can query whether assertions of independence and non-compliance might, at least sometimes, be a resistant response to this and other efforts throughout the system to minimise the personal agency, rights and resources of the mental health consumer. The tenor of Wales’ and Hiday’s argument support this:

Without the security of knowing that basic needs will be reliably met and a sense that he can be a master of his own fate, the patient will have little stake in compliance…

(Wales & Hiday, 2006, p. 462)
**Mental illness as source of influence?**

Even more intriguing however, is the possibility that we might view not only non-compliance but mental illness itself as a source of power. As Wales and Hiday (2006) identify:

> It is an unfortunate fact of political life that the principal leverage persons with severe mental illness have… is the threat that they will cost the state even more if their treatment needs and aspirations are not met.

*Wales & Hiday, 2006, p. 464*

The power of mental illness to effect change is present not only in resistant counter-strategies and non-compliance, but in non-engagement and, in fact, in any expression of mental health need.

### 3.2.2 STIGMA INHIBITS CAPACITY

**Elements of the ‘mentally ill’ person stereotype**

Stigma emerged strongly in the sampled literature in relation to the capacity of the mental health consumer. Rose (1998) described the long history of association between mental illness and dangerousness—a two-way association that sees people with mental illness as dangerous, and dangerous people as mentally ill (Seddon, 2008). There are other elements of the mental illness stereotype however including: low competence, low credibility and low intelligibility (Rogers & Pilgrim, 2014). Pustilnik (2005) and Perlin (2013) contribute the notion of ‘moral blame-worthiness’, and note the political strength of this attribution for denying resources.

**Contemporary refinements of the stereotype**

A more contemporary development involves some amendment of the historical stigma portrait. For, in contrast to the older, personalised notion of the mentally ill ‘monster’, the new discourse around risk and its application in the mental health field and corrections fields, has served to ‘de-personalise’ consumers (Rose, 1998). People with mental illness are now relatively featureless units of population requiring management based on objective assessment, and a totalised version of their needs and potential for damage in society (Castells, 2000; Johnstone, 2002; Laurance, 2003; Rose, 1998).
Effects of stigma on capacity to influence

The effects of stigma were comprehensively documented in the sampled literature. Particular reflections, related to the capacity of consumers to influence others in the direction of their interests, include:

- that stigma reduces use of health services (Benbow, 2007; Cooper, Corrigan, & Watson, 2003; Corrigan, 2004; Laurance, 2003) thus ensuring ongoing debilitation related to poor mental health;
- that stigma demoralises and disempowers the consumer (Johnstone, 2002; Laurance, 2003; Rogers & Pilgrim, 2014);
- that stigma makes consumers feel ‘other’—that is, excluded and rejected (Gray, 2002), and
- that it teaches consumers to be helpless and to expect (and demand) little (Laurance, 2003).

The literature suggests that consumers experience stigma as a discipline from the greater community that significantly circumscribes health, the self-image, and the scope of their capacity for effective agency in the wider community.

3.2.3 CONSUMER PARTICIPATION UNLAUNCHED

Consumer participation heralded

The period of this literature review broadly encompasses the so-called ‘decade of consumer participation’ commencing with Bracken and Thomas’ (2001) landmark article on post-psychiatry, which urged democratisation in mental health service provision. This trend paralleled developments in general medicine towards partnership between patients and professionals. The reviewed literature, then, featured a specific consumer participation discourse, now part of policy in most Western jurisdictions, heralding the benefits of increased patient involvement in mental health care. These included improved treatment compliance, quality of care, health outcomes and consumer satisfaction (Heenan, 2009; Hui & Stickley, 2007; Stickley, 2006; Stringer, Van Meijel, De Vree, & Van der Bijl, 2008).

Problems

But a great deal of literature also addressed the difference between the consumer participation ‘dream’ and its reality. Consumer involvement policies in action were 114.
identified as tokenistic, demonstrating a gap between policy and practice (Kelly, 2006; Martin, 2008, 2009; McAllister & Walsh, 2004). Some actually reinforced existing imbalanced power relations (Hodge, 2005; Laurance, 2003).

The change in the role of clinical professionals in the light of the consumer participation movement was also examined. Professional resistance was noted (McAllister & Walsh, 2004) but so was a sense of powerlessness in a changed consumer-oriented practice environment that had been inadequately re-framed for the purpose (Broer, Nieboer, & Bal, 2014).

The definition of participation
So what constitutes true involvement in the community for the consumer? This is contested. There are different notions of empowerment, not only as between the various stakeholder types in the mental health system (Martin, 2009; Starkey, 2003), but as between consumers with different mental health conditions (Pilgrim, 2005), and as between consumers of different political orientation (Pilgrim, 2005; Rogers & Pilgrim, 2014).

Disparity in consumer representation a barrier?
The political fragmentation of the consumer movement has been identified as a barrier to their greater power (Crawford & Rutter, 2004; Hernandez & Uggen, 2012; Kelly, 2006). Yet alongside the differences, there is much common ground, and value, also, in differentiation. Despite claims, often from within services rather than from consumers, that consumer advocates are non-representative, the views of politically active consumer advocate group members were shown to be very similar to ‘ordinary’ consumers (Crawford & Rutter, 2004). Morrison (2005) demonstrated that, even though the political orientation of consumer advocates ranged across a continuum from resistance to relatively compliant patient-hood, they shared concerns about injustice and powerlessness and the value of autonomous agency. Pilgrim (2005) profiled the development of the United Kingdom’s Mental Health Alliance, a group of disparate consumers, service providers and other stakeholders, who were able to come together to provide effective resistance to proposed government policy before the new Mental Health Act in 2007.

The difficulty in recognising and articulating needs for many people with active mental health conditions was noted (Kelly, 2006), along with the importance of that capacity as a necessary catalyst for political influence (Laurance, 2003).
Evidence-based medicine a barrier?
Most interestingly, the rise of evidence-based medicine, concerned with mental illness on a population basis, was identified in the review as working against the consumer participation movement, which promotes individualised medicine (Essock et al., 2003). There is apparent divergence on this issue as between academic psychiatrists pursuing a neurobiological agenda on the one hand, and practicing psychiatrists and their consumer patients on the other (Bracken & Thomas, 2006).

3.2.4 WHAT PRICE TREATMENT?

What type of services do consumers want?
Consumers want much more access to mental health treatment that is manageable, liveable, dignified and effective (Health Consumers’ Alliance of South Australia, 2009; Laurance, 2003; Mental Health Council of Australia, 2005; Roberson, 1992; Tsemberis & Eisenberg, 2000; Wales & Hiday, 2006). Although relative needs are contested across different sub-populations of consumers (Rosenberg, 2010), the consensus is that the overall need is much greater than existing services are able to meet (Hickie, Groom, McGorry, Davenport, & Luscombe, 2005; McGorry, 2010; Mental Health Council of Australia, 2005; Senate Finance and Administration References Committee, 2010; World Health Organization, 2001).

Attitudes to coercion
In the larger part, consumers do not favour the use of coercion, though they accept its necessity in very serious circumstances (Sheehan, 2009; Zinkler & Priebe, 2002). Many consumers, however, are repelled from engagement with coercive services (Allen & Smith, 2001; Dorn et al., 2006; Gilburt, Rose, & Slade, 2008; Laurance, 2003; Stanhope, Marcus, & Solomon, 2009; Swartz, Swanson, & Hannon, 2003). These consumers say that they would be prepared to engage with services, and comply with recommended treatment, if their basic needs are met (Bloche & Cournos, 1990; Jablensky et al., 2000), if the services provided are the ones they need and want (more holistic support and talking therapy, less emphasis on medication) (Laurance, 2003), and if they were provided with a view to the consumer being ‘master of their own fate’ (Johansson et al., 2006; Wales & Hiday, 2006).

Nevertheless, the review did show that consumers willingly sacrifice their autonomy to engage with treatment services that seek to discipline them (Klassen, 2011) in order to obtain access to desperately needed treatment (Lincoln, 2006; Wales & Hiday, 2006).
3.2.5 SYNTHESIS

NATO authority head

The literature yielded a considerable mass of reflections upon the lack of formal ‘authority’ possessed by consumers relative to other domain stakeholders (e.g. Kelly, 2006; Pustilnik, 2012; Stickley, 2006). By comparison with the state and psychiatrists at least, consumers have little institutionalised power, other than the influence embedded in human rights discourses which are resisted by other stakeholders, and have little formal recognition. It is observed, for example, that even modest consumer participation initiatives are often undermined by other stakeholders (Kelly, 2006; Martin, 2008, 2009; McAllister & Walsh, 2004).

How does this powerlessness arise? It might be argued that it arises from the fact of mental illness itself, a condition which can thwart the consumer, as stakeholder, from taking a more active role in furthering their own interests (Kelly, 2006). But if illness was the cause, sufferers of other chronic, physical health conditions would also be powerless and this is not the case. The notion of a ‘profound’ lack of power relative to other actors in the sector (Kelly, 2006) is identified in the literature as particularly characteristic of mental health consumers (Laurance, 2003).

Clues to understanding the operative power dynamic might be found in the experience of stigma—another characteristically mental, rather than physical, health phenomenon. Stigma is experienced by consumers as a form of discipline and a determination to exclude them, by the balance of a risk-obsessed community. Its effect correlates with the effect of the regulatory technologies of other stakeholders, such as the mental health law as exercised by the state, and psychiatric patient-hood, as imposed by clinicians. Each of these operates to de-personalise, exclude, disempower, and to deny or devalue the independent agency of the consumer.

Who is ascendant? Who is resistant?

The most common perspective arising from the literature positions the larger society hegemonically, and consumers as a resistant underclass. An alternative view, however, is that stigma and the other regulatory strategies of the non-consumer stakeholders might be identified as a systemic, energised, fearful resistance to the power of the consumer. The balance of stakeholders have great concern about the costs and consequences of mental illness, and about non-compliance in particular.
NATO nodality and treasure heads
Consumers exercise significant regulatory capacity under both the nodality and the treasure heads in the NATO schema. In the context of the evolved contemporary Western mental health system, consumers are the principal concern for the entire system, with negotiated relations with each of the other major stakeholders. This represents high ‘nodality’.

In this pivotal position, a consumer can exercise (despite their likely preference to do otherwise) their principal ‘treasure’, being the manifestation of mental illness or mental disorder itself. The effects of this exercise have major saliency with the balance of stakeholders and constitute the regulatory currency, or ‘treasure’, of the consumer. This ‘treasure’ of the expression of mental illness motivates the provision of services and assistance of the balance of stakeholder groups, as well as other less beneficent strategies such as stigma and imprisonment.

This characterisation of the response of the larger society as a form of resistance to the powerful ‘treasure’ of the manifestation of mental disorder helps to explain why conditions for consumers of mental health services are so profoundly degraded by comparison with their physical illness contemporaries. The resistance of the balance of stakeholders takes form as structural exclusion, coercive control, debasement of personal identity and the very strict rationing of services. All of these effectively remove personal agency from, and increase control over, the mental health consumer.

For consumers to increase regulatory capacity…
A low level of ‘organisation’ would be remedied by continued refinement of consumer participation initiatives and continued efforts to defragment consumer groupings. Low ‘authority’ might be remedied by increased institutional presence—for example, through such bodies as the relatively new National Mental Health Commission, and even by powerful, informal institutional sponsorship as exhibited by the Australian Broadcasting Commission during its regular and powerful mental health campaigns.

Genuinely enabling consumer responsibility for management of their mental health conditions would increase the regulatory capacity of consumers whilst reducing the costs and consequences for the balance of the system.

Resisting poor mental health in the balance of the community
Rather than reacting to the expression of mental disorder with ever-higher levels of attempted control and disempowerment, a more effective response from the balance of stakeholders may be to amplify and to re-direct resources to align more closely with
consumer’s needs and wishes, enhancing rather than depleting the consumer’s dignity and self-respect. This is a strategy that has not yet been tried. It would require system-wide recalibration. It could however amount to a much more cost-effective form of resistance by the balance of stakeholders to the effects of poor mental health in the community.

**Synthetic argument**

Consumers are often spoken of, and written about, as powerless. Certainly, consumers with mental health conditions, as a group, are afforded low socio-political status within the community. But consumers also exercise considerable influence and activate a great deal of process in society by virtue of possession of the condition of mental illness itself. Mental illness is a form of regulatory capital with considerable potential for cohesive exploitation from which all stakeholders, but particularly consumers, could benefit. Currently however, its potential is not only ‘not actualised’ but actively stymied, by its low ratings in two other of the NATO arms of regulatory capacity—‘authority’ (socio-politically) and ‘organisation’ (fragmented). Consumers’ low actualised regulatory capacity leaves them vulnerable to strong resistant responses, such as the imposition of stigma, and the provision of sub-optimal treatment modes, from other domain members.

**Central synthetic construct**

characterising the regulatory capacity and agenda identity of the consumer within the Phase II policy domain:

‘stonewalled’
3.3 THE COMMUNITY

3.3.1 VALUING GOOD MENTAL HEALTH

Mental health a prominent issue, particularly for Australians

The literature shows strong concern in the community for the provision of good mental health care. A review of attitudinal studies showed that a majority of people believe that people with mental health conditions should receive help (Angermeyer & Dietrich, 2005). In 2010, concern about mental health was rated as one of the top three concerns of Australians about the future (Ipsos MORI, 2010). This is consistent with poll findings in Australia on the popularity of spending to improve hospitals and medical services more generally (Research Australia, 2012).

Better understanding improves public attitudes to mental health spending

Several studies show that people favour more public spending on mental health services if they have experience of mental health problems, either personally or through a family member (Angermeyer & Dietrich, 2005; Barry, 2006; McSween, 2002). McSween used this association to argue, then, that “mental health is policy for the few” (McSween, 2002, p. 343). But data about high, unmet mental health need is widely circulated in the Australian public domain (Hickie et al., 2005; Lourey et al., 2012). More Australians than ever before are now in a position to understand and engage with mental health under-servicing as a policy problem.

3.3.2 ‘TO STIGMATISE’...

The effect of stigma on the consumer has been addressed previously at sub-section 3.2.2 but, as Benbow (2007) notes, the action of the verb ‘to stigmatise’ appeared as a separate phenomenon within the sampled literature.

The community’s negative portrayals of mental health consumers

Despite more than a decade of stigma-reduction policies, the media continues to negatively portray people suffering from serious mental illness (SANE Australia, 2010; Stout, Villegas,
Although there is a research gap on the link between exposure to negative media stereotypes and attitudes to mental illness (Stout et al., 2004), the stereotype of the rabid, violent madman is still alive and well (Pustilnik, 2012; Rogers & Pilgrim, 2014; Seddon, 2008). Rose (1998) refers to the media’s obsession with adverse events involving people with mental health conditions. Despite evidence that people with mental illness are responsible for only 1 in 20 violent crimes (Fazel & Grann, 2006) media commentators and organisations continue to link gun violence, particularly, with mental illness:

...There was a period, in the 1960s and 1970s, when mental illness was celebrated in films like ‘One Flew Over the Cuckoo’s Nest’ as a plausible response to an insane society. It was an entertaining literary conceit…but it ignored the reality of people like Loughner or the guy who shot up Virginia Tech a few years ago—or the near-weekly nut-jobs who attack schools and fast-food restaurants, take hostages at malls, or merely wander the streets babbling incoherently, threatening bystanders and scaring the bejeezus out of everyone. We have a responsibility to protect ourselves against these people...

(Klein, 2011)

This excerpt from an article by popular Times.com blogger Joe Klein seeks to replace softening community sentiment about mental health suffering with primal fear for personal safety. Klein invokes the neo-liberal strategy of self-responsibility—crafting positive action in relation to this fear into the aspirational profile of the ‘good community member’.

Thus, the community is conditioned to regard people with mental illness as unpredictable, violent, dangerous, to be avoided. This discourse receives further impetus from the broader, and currently escalating, pre-occupation with risk and uncertainty more generally, and with policy-making for better domestic security (Furedi, 2008).

The community holds consumers responsible

There is considerable evidence that the community holds people with mental illness morally blameworthy for their unwellness, and for the acts they commit whilst unwell (Benbow, 2007; Luchins, Cooper, Hanrahan, & Rasinski, 2004; Pustilnik, 2012; Wolff, 2002). Pustilnik (2012) argues that the public’s apparent preference for policies which jail, rather than provide services to, people with mental illness issues is founded in the belief consumers are responsible for their own condition.

In addition then to the creation of a ‘spoiled identity’ (Rogers & Pilgrim, 2014) on the part of the consumer, the community’s action ‘to stigmatise’ becomes a force in the electorate with potential to influence state policy and the service system.
3.3.3 ELECTORAL INSTABILITY

Are governments responsive?
It is claimed by some commentators that governments are responsive to public views on welfare issues generally (Brooks & Manza, 2006; Soroka & Wlezien, 2004) and about their views on mental health issues in particular (Wolff, 2002). Certainly, states might be judged to demonstrate extreme responsiveness to community concern about safety if the speed of initiation of inquiries and legal changes after serious adverse events involving people with alleged mental health conditions is any guide (Flug, 2003; McSherry, Keyzer, & Freiberg, 2006; Wolff, 2002).

The effect of unstable community views: no action
Other literature, however, plays down the connection between policy and public opinion, particularly in relation to health issues. Burstein (2006) notes that the community’s view will be overcome by the preferences of other stakeholders if it has weak or inconsistent opinions. Oliver (2006) and Kronenfeld (2011) believe that this is precisely the case in relation to most health issues, where instability characterises the public view. They were writing in the US context however, where health issues are judged to be second-tier concerns (Kronenfeld, 2011). In Australia, where national concern about mental health is higher (Ipsos MORI, 2010), significant recent improvement in services and funding is claimed by the state (Liberal-National Party Coalition, 2013) although these claims have been disputed as a “mirage” (Rosen, 2015).

Australians ambivalent about improving mental health
As noted previously, the literature reveals that the views of the community about mental health consumers loop around two separate pillars—the one founded on beneficence, in the sense that mental health consumers need help and should be helped, and the other mired in fear, in the sense that mental health consumers do not really deserve the usual standard of care and services, and are generally to be avoided. This attitudinal ambivalence may explain why spending on mental health in Australia still represents less than half of its disease burden (Rosenberg, Mendoza, & Russell, 2012) and the quality of mental health services and facilities are significantly lower than what would be tolerated in other branches of medicine (Laurance, 2003).
3.3.4 THE POWER OF FEAR AND RISK

The effects of risk culture on sub-populations

Conceptualisation of ‘the risk society’ became increasingly sophisticated in the decade covered by the Phase II review, with the ramifications for mental health services receiving special attention in the sampled literature. Beck (2009) describes the sociological effects of the perception of chronic risk in a security-obsessed world. These include the dissolution of distinctions. “Risk functions like an acid bath” (Beck, 2009, p. 3) in which all the other characteristics of a person or group are annihilated—including such classical distinctions as good and evil. In social policy terms, the risk phenomenon promotes vulnerability-led policy options at the expense of the strengths-based initiatives that have real potential for building social capital (Furedi, 2008). These options often involve the separation of risky citizens from the balance of the community, further disassociating already-marginalised sub-populations (Silver & Miller, 2002).

Fear of risk

Rose (2009) builds on Castel’s (1991) description of the de-personalising effect of risk in the practice of psychiatry, describing the transition from a dangerousness discourse to a risk discourse in the mental health sector. As an accretion to the more traditional fear of the stereotypical, dangerous mental health consumer, the community is now additionally concerned with fear of the risk relating to that person (Rose, 1998), being the fear of something that does not currently, and may never, exist. Furedi refers to the same phenomenon as the creep of “possibilistic thinking” being the fear of, and response to, not only likely threats, but of what might go wrong (Furedi, 2008, p. 646).

The cost of paranoia

A range of authors argue that public demand for protection from the possible flowering of risk contingency—in the form of adverse events involving consumers—occurs at increasing global cost and effect on the other more beneficent aims of the mental health system, and on the rights of the consumer (Langan, 2009, 2010; Langan & Lindow, 2004; Large et al., 2011; Monahan et al., 2001; Szumukler, 2001b, 2003; Wolff, 2002). Rose (2009) notes the unlikely prospects for this chorus in an electoral environment that continually looks for more, rather than less, public protection.

In the drama of fear and accusation in a culture of blame and pre-occupation with adverse events, a simple and valuable point is lost: that policy to provide better access to wanted and needed services would not fail for want of custom (Wales & Hiday, 2006) and
would likely result in better, and more cost-effective protection for the community (Large et al., 2011; Laurance, 2003; Szmukler, 2001a, 2003; Szmukler & Rose, 2013).

**Possible positive future directions for the risk pre-occupation**

There are suggestions in the literature of alternative future directions for the risk discourse, however, that are possibly more cost-effective, beneficent and rights-congruent. First, Kooymans (2007) argues that if we insist on assessing consumers for risk, we should assess not only for the risk of violence and self-harm but for the risk of a number of other interrelated factors such as homelessness, unemployment, victimisation and substance abuse. Secondly, a number of writers record the possibility, at least, of consumer empowerment and greater consumer autonomy arising from the use of risk technologies (Langan, 2009). The flowering of this contingency is subject to certain conditions, however, such as the reduction of the blame culture inhibiting the exercise of psychiatric discretion (Evans & Harris, 2004), and the nature of the surveillance and enforcement used (Langan, 2009; Zureik, 2003). Others suggest that a phenomenon like risk, assessable only at a population level, should be managed by population-level policy response—such as preventive programs, and substance abuse reduction policies (Langan, 2009; Szmukler & Rose, 2013).

### 3.3.5 SYNTHESIS

**Two views**

The literature discloses a diffuse, ambivalent agenda for the stakeholder identified as the ‘community’. On the one hand, the community demonstrates interest in having people identified as mentally ill cared for. On the other hand, the community seeks protection, and separation, from consumers. Angermeyer (2005) reported a study in which more than two thirds of major mental health service providers in the UK had faced opposition to the location of their facilities from local residents in the previous five years.

**Mental health issues become more everyday**

There are some signs that the community may be shifting towards greater understanding and tolerance, and that the strength of stigma may be reducing in relation to at least some types of mental health conditions (SANE Australia, 2010). This may be a function of increased familiarity with mental health issues, as aired in the public domain, and within family and social networks (Angermeyer & Dietrich, 2005).
Fear of the risk of…?
But attitudes continue to be influenced by sensationalised media coverage of adverse events involving mental health consumers which seeks to stimulate its audience by generating fear of difference and moral blame-worthiness (Wolff, 2002). The message is that people identified as mentally ill are both dangerous and bad (Pustilnik, 2012), that the risk they present must be contained (Silver & Miller, 2002), and that someone—psychiatrists, services and/or the government—must bear responsibility for adverse events (that only very occasionally happen) (Szmukler, 2003).

NATO capacity heads
The literature demonstrates that the community possesses no particularly strong capacity to influence under the ‘nodality’, ‘authority’ or ‘organisation’ heads. By contrast, it possesses, at least potentially, a very significant regulatory capacity in the ‘treasure’ of its electoral power. But this power remains latent because of the inconclusiveness of the community’s views on mental health (Burstein, 2003, 2006).

The community’s concerns about improving mental health in the community appear to be surmounted by an overriding concern for personal security. This fear supports continuing political pressure in most Western jurisdictions for more action for prevention of adverse events, and increased containment of the consumers assessed to be likely to cause them (Akuffo, 2004; Rose, 1998).

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<th>Synthetic argument</th>
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<td>The community has strong concerns about the prevalence of mental health in the community with indications that understanding about mental health issues may be increasing. At the same time, however, there is great concern in the community for its own safety and protection. The instability resulting from these simultaneous, and mostly contradictory, interests dilutes the practical impact of the largest trove of regulatory capital in the domain, being the community’s electoral power.</td>
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<th>Central synthetic construct</th>
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<td>characterising the regulatory capacity and agenda identity of the community within the Phase II policy domain:</td>
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<td>‘fearful ambivalence’</td>
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3.4 THE PSYCHIATRIST

3.4.1 DISREGARD

A second stigma?

A stigma around psychiatrists has been identified (Persaud, 2000; Salter, 2003) with several negative stereotypes of psychiatrists evident in the literature. Psychiatrists have been depicted in the public domain as incompetent, eccentric, uncaring, manipulative, abusive and lecherous (Hiiday, 2011; Sartorius, 1998; Stout et al., 2004). The medical specialty of psychiatry enjoys only low status amongst medical students and general health professionals (Cutler, Alspector, Harding, Wright, & Graham, 2006; Cutler et al., 2009), and a significant proportion of Australians report feeling uncomfortable about the prospect of talking to a psychiatrist (Persaud, 2000; Sartorius, 1998). Persaud (2000) queries whether reluctance to engage with psychiatrists relates to the stigma associated with psychiatrists, or to mental illness itself. He concludes that, in any case, both stigmas are reinforced by avoidance behaviour, and that people with mental health needs suffer as a consequence.

Reasons for silence

I have found it curious in the past that, despite the prominence of a very small number of individual psychiatric clinician activists, psychiatrists as a profession stay relatively silent in discussion around mental health issues in the public domain. The review literature reveals some clues as to why. Salter (2003) suggests that the reasons for absence of the professional voice of psychiatry in public debate might include psychiatrists’ lack of credibility in the community, and, simply, that psychiatrists are media-shy. Psychiatrists appear to have developed either a fear of, or contempt for, the media (Lamontagne, 1990; Ruben, 1995).

Professional associations must step up

Salter (2003), Persaud (2000) and Sartorius (2011) urge more attention to engaging in public debate at the level of the professional association:
[Psychiatrists are] in grave danger of being ignored while health care debate in the media is increasingly infiltrated by non-medical lobbying organisations… Eventually, lack of public credibility will produce a government unafraid to ignore psychiatrists' views… If psychiatrists persist with a negative attitude towards media liaison they will be looking the wrong way when the next threat to their autonomy arrives.

(Persaud, 2000, p. 2)

If more effective engagement by the profession does not occur, Persaud warns, psychiatrists’ capacity to influence will continue to drain away.

3.4.2 MANAGERIALISM

Sources of change
Over the course of change in the ethos of state-provided health service to a neoliberal supply and demand arrangement (Carney, 2008; Malone, 1998; McArthur & Montgomery, 2004), the public psychiatric clinician has become subject to a range of new, non-therapeutic imperatives such as cost containment, risk management, quality assurance, accountability reviews and outcome management (McArthur & Montgomery, 2004; Rose, 1998; Sawyer, 2011). Other influences cited in this shift include the quasi-marketisation of health services (Plastow, 2010; Sawyer, 2011), the reduction of the ‘almshouse’ function of the hospital (Denzin & Lincoln, 2007), evidence-based medicine (Essock et al., 2003), the rise of the risk phenomenon (Rose, 1998) and consumer participation initiatives (Browne & Hemsley, 2008).

Loss of clinical leadership and autonomy
Psychiatrists in public practice are no longer the leaders in a realm where legal, political and economic concerns now predominate (Altamura & Goodwin, 2010). Rather, they are part of ‘clinical management teams’, with other types of mental health professionals and managers (O’Connor & Paton, 2008). This working arrangement reflects a significant loss of leadership and clinical autonomy. Roles and issues of relative authority in new forms of clinical practice can be ambiguous (Hutschemaekers, Tiemens, & Kaasenbrood, 2005), and psychiatrists may be subject to supervision by non-clinical managers (Pridmore, 2006). The clinical professionalism of the psychiatrist, still much valued by the psychiatrists themselves (Bhugra, 2008), appears to others to be in decline or, at least, under considerable pressure (Little, Lobb, & Atkins, 2007).
Psychiatrists’ reaction to the new order

Psychiatrists describe this loss of opportunity to exercise their true expertise and to exercise professional autonomy with sadness and anger. Plastow objects to the corporatised state “re-defining what we do” applying terms such as ‘service provider’ which posits clinicians as “mere vendors” (Plastow, 2010, p. 301). Pridmore compares administrators to “wily apes” who, armed with their “skill in the manipulation of numbers and their knowledge of so-called universal rights” have “wrenched” influence from “wise” clinicians (Pridmore, 2006, p. 336). Shea (2004), also, decries the rise of the administrator over the clinician, and the predominance of the cost-containment model of health service provision. He opines the likely reasons for the absence of fully-fledged resistance to the reduction of professional discretion:

apathy...the forlorn hope that things might improve, a need to keep the administration on side in case you need something from them, knowledge of what has happened to other staff who have upset the administration...[and] a feeling of being out of one's depth when dealing with...financial concepts, and a desire not to be abused, ridiculed, ignored or sworn at...

(Shea, 2004, p. 335)

Resistance or compliance with ‘new managerialism’

In relation to the regulatory imperatives of the new regime, there is evidence from psychiatrists of resistance, and also of compliance, with some suggestion of a translation in progress from one to the other. Mannion (2010) describes the continuation of powerful clinical hegemonies in many public health facilities where the new managerialism is often subverted by clinicians (Joyce, 2001; Waring, 2007). Waring (2007) suggests that this subversion might be a form of adaptive regulation—a possible stage on the way to a re-fashioned vision of professional autonomy for the clinician. This form admits a larger stripe of managerialism, but also enlivens self-regulation in lieu of administrative control over clinical practice. O’Connor and Paton (2008) say that psychiatrists and managers should see themselves as ‘married’ rather than in a hierarchical relationship, addressing the consequences of the maxim that “every clinical decision is a resource decision and every resource decision is a clinical decision” (J. W. Sparks, 2000, p. 3).

That a possible end to the future public psychiatrist’s malaise might include less resistance and more cooperation is contested, however. In explaining his strong view that patient and managerialist interests are irreconcilable, Shea distinguishes continuing clinical
practitioners with managerial orientation as “former colleagues who adopt a different set of values...values far removed from those inherent in the patient-therapist relationship” (Shea, 2004, p. 366).

It is clear that a range of responses exist in relation to the imposition of a managerialist working environment, perhaps particularly for the current cohort of clinicians who still remember and value a different quality of professional experience.

3.4.3 Risk-regulated practice

Risk transforms the problem of mental health
The literature addresses the effects of the developing focus on risk in the problematisation of mental illness. Joan Langan identifies risk as a “key organising principle” in the problem of welfare and health services provision (Langan, 2010, p. 469). Rose (1998) describes how the application of risk technologies in psychiatric practice re-frames the mental health problem for the state in terms that give the appearance, at least, of the manageability of its inherent uncertainties. Poor mental health is de-personalised and systematised by the risk discourse.

Psychiatrist role change in a risk-focussed system
Psychiatrists are tasked as the principal agents of responsibility in addressing the problem of mental health, as framed through the risk focus. It is suggested that the public psychiatrist’s subjectivity has been transformed from that of a respected, expert, care-giving crafts-person to that of a harried risk administrator, swamped by paperwork, routine and procedure (Sawyer, 2011). Rose (1998) and others argue that the task of a psychiatrist is now less about working creatively towards therapeutic outcomes for unique individual patients, and more about administratively sorting sub-populations of more or less risky consumers (see also Langan, 2009). But Burns (2010) says this is going too far. While acknowledging that the focus of the language has shifted from a therapeutic to a risk orientation, he argues that most psychiatrists still pursue their practice with patient beneficence to the fore, re-framing their language in the risk terminology, if necessary, to ensure the desired treatment pathways.

Variations in response over the trajectory of the risk phenomenon
The irony that it is now apparently necessary to cloak the exercise of doctorly care and discretion in a language of dangerousness and risk appears to be lost on at least one—the
newest—generation of clinicians who have ‘grown up’ with the risk paradigm (Hiday, 2011), and for whom the objectives of therapy and management may have become fused (Dallaire, McCubbin, Morin, & Cohen, 2000). This was not the case, however, at the time of the introduction of risk criteria into mental health laws, with many psychiatrists expressing frank astonishment at the shift in practice and results for their patients that would have resulted if they adopted the new criteria at face value (McCready & Merskey, 1981; Page & Firth, 1979; Sharpe, 1979; Vincent, 1979).

Wide variation in risk-regulated practice
Even so, the literature reveals a range of views about the effects of risk regulation on the exercise of clinical discretion in practice (Evans & Harris, 2004; Langan, 2009). Husum et al. (2008) modelled three fundamental, yet distinct, attitudes of clinical staff in relation to the use of risk-regulated involuntary treatment—the first, that it was acceptable for the purposes of security; the second, that it was acceptable for the purposes of treatment; and thirdly, that it was not acceptable. Zinkler and Priebe (2002) found that, despite very similar risk-oriented legal criteria in European countries, rates of detention varied between them by a factor of nearly twenty. Kemshall and Maguire (2001) found that the clinician’s personal orientation to the application of risk criteria was a relevant factor in clinical decision-making, supporting the earlier research of Engleman et al. (1998) in which it was found that clinicians’ widely divergent attitudes impinged significantly on their practice of risk-rating. All of these results are consistent with Evans and Harris’ (2004) assessment that, in the literature at least, there is a state of impasse on the effect of regulation on the exercise of professional discretion.

### 3.4.4 BLAME AND MORAL DISTRESS

A twin-set of disciplines
The existence of a culture of blame (N. O’Connor, Beth Kotze, & Murray Wright, 2011a) within psychiatric practice, with pernicious effects on the practice and identity of clinicians, emerged as a strong theme in the review. The literature details a twin-set of psychological disciplines (Rose, 1998) imposed upon public psychiatrists through this culture: the fear of blame for adverse events, and the moral distress engendered when the clinician’s perception of ‘doing the right thing’ for a patient conflicts with action predicated on the fear of blame (Austin, Kagan, Rankel, & Bergum, 2008).
Fear of blame
Rose (1998) and Langan (2009) argue that risk regulation supports the blame culture. They say that it is central to the psychiatrist’s revised role under the risk paradigm to bear responsibility both for the accuracy, and for the negative consequences of inaccuracy, of a consumer’s risk assessment. This responsibility, and the fear that it engenders, leads to conservative exercise of professional discretion (Evans & Harris, 2004). Laurance describes how his inner-city psychiatrist informants worried about who would be blamed:

[any variation from recommended perfect practice could lead to an unpleasant afternoon on front of a suicide inquiry panel and the humiliation of being named in a report.](Laurance, 2003, p. xvii).

Moral distress
Psychiatrists experience feelings of powerlessness, guilt, self-blame and betrayal arising from the ethical dilemma presented when a conservative, self-protecting clinical decision conflicts with “the silent but radical, ethical demand” of alternative, patient-oriented action (Dahlqvist, Söderberg, & Norberg, 2009, p. 242; Langan, 2009).

Johansson et al. (2006) presents moral distress differently, referring to the psychological dissonance generated by the responsibility of being ‘in control’ of outcomes for a patient where control is, in reality, illusory. The fundamental impossibility of the flawless carriage of the social control function—part of the deal for the public psychiatrist in a mental health system dominated by the risk paradigm (Rose, 1998)—is a desperate irony that gives rise to a siege mentality in some psychiatrists (Laurance, 2003).

Psychiatrists’ response
To manage their course within a blame culture, practitioners routinely make decisions with an eye to the tribunal (Rose, 1998); avoid taking on difficult cases where things could go wrong (Wolff, 2002); and use mental health law to “cover their asses” (Aviram, 2011). Many of them leave the system altogether (Laurance, 2003).

O’Connor et al. (2011b) urge a more positive approach, suggesting that public psychiatrists resist all external influences exerting blame, and instead re-take control and renew support through processes of peer review and accountability.
3.4.5 SYNTHESIS

Crisis of identity
One movie stereotype of psychiatrists portrays them as powerful and controlling. Yet the literature reveals a prevailing tenor of dejection in their professional culture. Public psychiatrists seem caught between the ‘rock’ of their genuine care and concern for patients, and the ‘hard place’ of their responsibility, delegated through risk regulation, for their patients’ actions. The literature also reveals concern for loss of valued professional status, and loss of discretion to exercise their expertise as their training in treatment and care optimally suggests. Psychiatrists do appear, however, to be interested in reclaiming, or at least maintaining, their professional status and autonomy, and in resolving the dynamics responsible for their frustration, fear, anger and sadness.

Capacity to influence
Public psychiatrists don’t fare particularly strongly in any of the NATO capacity categories. They have poor relations with the media, and as a consequence also with the community and the state (Persaud, 2000). Psychiatrists’ ‘nodality’ is, therefore, relatively poor. There is some capacity under the ‘organisation’ head, with universal membership and wide geographical coverage in the global, national and local structures of their professional associations. This organisational capacity appears to be under-exploited however.

As noted, the psychiatrists’ innate professional authority, once strong, appears to have eroded in recent decades, in parallel with the rise of managerialism, and the burgeoning impact of the risk regulation in the mental health sector. I conclude, in fact, that the expression of the risk paradigm has now effectively circumscribed the regulatory capacity of psychiatrists under the head of authority. Deeming and enforcement powers of the justice system, and of the legislature, have been made available to psychiatrists through delegation under mental health law. But it is the police power of the state that is impressed upon consumers in these processes, not any authority or respect engendered by psychiatric professionalism.

If anything, it might be argued that their ‘responsibilisation’ under mental health law detracts from trust in the expertise of psychiatrists to guide the passage to restored health, the unique ‘treasure’ that psychiatrists still undoubtedly possess. This regulatory capital has become devalued, however, with the rise of the multidisciplinary team, and the anti-therapeutic effects of risk-focussed usual care.
The current balance of relations in the mental health sector policy domain suggests an alternative and more current form of regulatory capital. This is: that psychiatrists are extremely valuable to the balance of domain members in their preparedness to bear responsibility for assessment and management of high-risk patients, and blame for the inevitable failures of these processes (Aviram, 2011), whilst at the same time striving to provide genuinely therapeutic treatment, and, miraculously, to get up, go to work, and to Prosecute this near-impossible set of duties every single day.

**Synthetic argument:**
The nodal capacity and authority formerly enjoyed by psychiatrists as central to, and as undisputed leaders within, the mental health system, as well as the considerable value of the ‘treasure’ of the psychiatric expertise itself, has been compromised by poor public relations; creeping managerialism and the contraction of clinical autonomy; the conflation of risk and clinical need in practice, and psychiatrists’ own moral distress. Professional despair, differentiation and fragmentation within their own ranks deflate the expression of organisational capacity. Public psychiatrists’ efforts to adjust their compliance to, or subvert, external pressures suggests recognition of latent or unexploited regulatory capacity (under all heads) or at least a level of resistance to its further depreciation.

**Central synthetic construct**
characterising the regulatory capacity and agenda identity of the community within the Phase II policy domain

‘besieged’
3.5 THE STATE

3.5.1 A MONOLITHIC STATE?

In outlining a brief history of the development of regulatory policy in mental health in the US, Hiday (Hiday, 2011) describes how the relationship between the state’s health and justice systems have waxed and waned over the last century, but most recently in the direction of new cooperation between them in concerted attempts to control deviance. On another view, the convergence occurs in the function of risk management (Rose, 1985; Steering Committee for the Evaluation of the Second National Mental Health Plan 1998-2003). Carney (2010) outlines a form of pragmatic collusion between the Australian mental health and justice systems that may, in effect, subvert the letter of the law. These perspectives are supported by Dallaire et al. (2000) who explain the current intersection of law and public psychiatry on the basis of the interchangeability of the concepts of treatment and control.

3.5.2 INTERESTS, POLICIES AND OUTCOMES

There is a considerable amount of discussion in the literature about the true agenda of the state in the mental health policy domain.

Treatment v. control

One debate distinguishes between the objectives to provide for the needs and rights of people with mental health conditions on the one hand, and to control consumers for the protection of the community on the other. A segment of the literature argues the inappropriate conflation of these objectives (Allen & Smith, 2001; Fistein, 2011; Hale, 2007) in policy-making. For the opposing side, there are claims and evidence for the successful integration of the objectives (Aral, Burris, & Shearing, 2002; Sjöström, Zetterberg, & Markström, 2011; Winterton, 2007).

Several authors argue that the relatively low availability and quality of mental health services, and the apparently pivotal role of the involuntary treatment system, as indicating a state preference for policy provision for control over care (Akuffo, 2004; Bindman, 2004;
There is supporting literature indicating a lack of concern for quality of care. Lester, for example, reports that mental health facilities are dirtier than general medical facilities in the UK (Lester & Glasby, 2010). This claim was echoed in a government report from one Australian jurisdiction which referred to conditions at a public psychiatric facility as “filthy”, “stale” and “unkempt”, noting that bed numbers had been spray-painted in large blue lettering on the walls in some wards, and the presence of graffiti (Human Rights Commission, 2009, p. 47).

**Mental health is an extraordinary policy challenge**

Others recognise that servicing the complexity of the phenomenon of mental health need in the community presents an enormous, perhaps an insuperable, challenge for the state (Doessel et al., 2008; Whiteford, 2005; Whiteford & Buckingham, 2005), with the involuntary treatment system figuring principally as a means for the state to organise itself within the morass (Churchill, Owen, Singh, & Hotopf, 2007; Monahan et al., 2001).

**But is the state transparent?**

The literature recognises the mismatch between stated mental health policy intentions, and mental health policy as enacted and implemented. There are differences between what is attempted and what is achieved (Ajzenstadt, Aviram, Kalian, & Kanter, 2001), lack of correlation between explanations of proposed policy and its purported instrumentation, and claims that the state is disingenuous in the representation of its objectives for its mental health law (Akuffo, 2004).

### 3.5.3 ATTENDING TO THE ELECTORATE

As previously noted, the link between public opinion and mental health policy change by the state is mainly recognisable in the aftermath of widely publicised adverse events (Wolff, 2002). There are other discourses about mental health in the public domain, however, that have some salience in the electorate, each of which establish some level of purchase, from time to time, as drivers of state policy.
Views and issues for factoring by the state
These public discourses, all contested, are wide-ranging and multidisciplinary. They include discussions in the areas of: consumer rights and anti-discrimination (Gostin & Gable, 2004), including the concept of self-determination (Dawson & Szmukler, 2006) and the right to health and service (McSherry, 2008); ‘therapeutic jurisprudence’ perspectives (Freckelton, 2008); the effect of risk criteria in mental health laws (Large et al., 2008); consumer participation and patient choice (N. Jones, 2012); the reduction of stigma (SANE Australia, 2010); the culture of blame (Aviram, 2011); the problem of fragmentation of services (Social Inclusion Unit, 2006); completion of the de-institutionalisation project (Whiteford, 2005); cross-jurisdictional service planning (M. Butler & Macklin, 2012); the distribution of mental health need and resources (Burgess et al., 2004); clinical and service accountability (Brown & Pirkis, 2009); the rise of evidence-based medicine (Tanenbaum, 2003); the medicalisation of the broader social phenomenon of mental ill-health (Shera, Aviram, Healy, & Ramon, 2002); the problem of mental illness in prisons (Pustilnik, 2012); mental capacity laws (Richardson, 2007); and the impact in the sector of ‘market-think’ (Swenson, 2008).

The response of the state
As they arise, the views in these debates are likely to affect at least the style and technique of the state’s rhetoric (R. Sparks, 2001) in mental health policy and action, which is carefully constructed for public consumption according to the issues of the day (Gewurtz, 2011; Seddon, 2008; Ungurean & Csiki, 2005).

The contested complexity of this vast array of views and issues on the part of interest groups and the public may help explain why mental health policy reform is often placed in the state’s ‘too-hard basket’ (Barnett, 2010), and why change in the state’s positioning in mental health policy is minimal. By minimising the scope of proposed change, potentially divisive debate is reduced (Oliver, 2006). There is recognition, also, amongst policy-makers and legislators, of the costs associated with change (Essock et al., 2003), and the prevalence of a notion, described by Oliver (2006) as an example of bounded rationality, that it is easier to build incrementally on existing systems than develop new ones (Joyce, 2001; Rees, 2007).
3.5.4 Budget Pressures

Cost is the major concern
The robustness of the economic times overall will certainly have a bearing on any public health spending (Oliver, 2006), but whether the nation is enjoying famine or feast it appears that a restricted budget is, and always has been, the most profound policy driver in the sector (Anfang & Appelbaum, 2006; Joyce, 2001; Rees, 2007; Whiteford & Buckingham, 2005). Joyce (2001) argues that rationing and prioritising now constitute dominant discourses in mental health servicing. Similarly, Shera et al (2002) and Essock (2003) identify that cost-containment and accountability are the major pre-occupations of mental health policy-makers and legislators.

But cost-effectiveness is poor
It is significant, then, that a sizeable section of the reviewed literature addresses the poor cost-effectiveness of the systems supported by current policies, including the high cost of an involuntary treatment system, the opportunity cost of lack of access to better quality, more highly desired and cost-effective voluntary services (Hiday, 2009, 2011; Lawton-Smith, Dawson, & Burns, 2008; Monahan et al., 2001; Wales & Hiday, 2006), as well as the staggering costs of the routine gaoling of non-violent, mentally ill adults and children (Pustilnik, 2012).

And neo-liberal devolution to the market is difficult
The limited scope for ‘marketisation’ within the mental health field may also be restraining the types of cost-effectivity reforms the state seems willing to embrace in other health sectors (Swenson, 2008).

3.5.5 Synthesis

Agenda identity
The literature reveals that the interests of the state in the mental health domain seem very similar to its interests in any other social policy sphere. It seeks to minimise expenditure overall, maximising collective benefits within budget constraints, and to manage interest group pressures. Principally, however, it seeks to at least to appear to attend to the sentiments of the electorate. Culturally, the state is diverse, with many units and agencies with specific remits, though state law and health agencies are currently cooperative.
NATO capacity heads
The state’s ‘nodality’ in relation to all other domain actors is direct and high, with strong reciprocal relations in place with clinicians, the community and consumers. Its regulatory capacity in terms of the authority head, also, is high as the state is the only actor with capacity for formal regulation of the conduct of consumers and clinicians. The increase in managerialism in mental health facilities, and imposition of risk-focussed usual care protocols, has effectively encroached upon the professional autonomy of psychiatrists, re-directing a significant quotient of clinical authority to itself. In relation to ‘organisation’, the fragmentation of services in the continuing era of de-institutionalisation, the continued medicalised focus in the problematisation of mental health, the disparate range of mental health issues, the necessary intersection with other social service policy silos and the Australian system of federalism combine to petrify the state’s capacity to organise to ‘get things done’ in mental health.

**Synthetic argument**
The state possesses, and actualises, high regulatory capacity. In a complex health service sector, it both controls and provides services, as well as funding. Mental health law, risk-based service protocols and the de-professionalisation of public psychiatry ensures the arrogation of authority to itself. But the complexity of this level of involvement, along with the complexity of policy drivers, constipates the state’s capacity to organise to respond effectively to its own concerns.

**Central synthetic construct**
characterising the regulatory capacity and agenda identity of the state within the Phase II policy domain:

‘steering and rowing—in place’
3.6 FINAL SYNTHESIS

3.6.1 SUMMARY

A summary of the critical interpretive syntheses of the Phase II network governance study, per actor, is set out in Table 6.
### Table 6
**Summary of results of Phase II Network Governance sub-study: Critical interpretive synthesis**

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Culture</th>
<th>Values</th>
<th>Interests</th>
<th>'Nodality'</th>
<th>'Authority'</th>
<th>'Treasure'</th>
<th>'Organisation'</th>
<th>Overall capacity rating</th>
<th>Salience of access objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumers</td>
<td>Debased</td>
<td>Respect Full citizenship. Autonomy Access to effective desirable treatment. Participation Human rights.</td>
<td>High Pivotal role in system. Consumer advocates have some purchase.</td>
<td>'Profoundly' low.</td>
<td>Medium Manifestation of mental health condition.</td>
<td>Low</td>
<td>Fragmented, despite consumer organisations.</td>
<td>Medium</td>
<td>Very high</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Culture</td>
<td>Values</td>
<td>Interests</td>
<td>‘Nodality’</td>
<td>‘Authority’</td>
<td>‘Treasure’</td>
<td>‘Organisation’</td>
<td>Overall capacity rating</td>
<td>Salience of access objective</td>
</tr>
<tr>
<td>-------------</td>
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</tr>
</tbody>
</table>


3.6.2 RELATIVE REGULATORY CAPACITY

One of the clearest outcomes of the Phase II analysis is the notion that regulatory capacity can encompass potential, as well as deployed, capacity to influence. The differentiation is a valuable one for determining a policy response to the results.

The results of the synthesis in relation to the ‘relative regulatory capacity’ research question, addressing both of these types of capacity to influence for each of the four relevant actors, are set out below:

Consumer

I have rated overall regulatory capacity of the consumer as ‘medium’ on the basis of low levels of ‘authority’ and organisational capacity, balanced by higher assessments for nodality and ‘treasure’.

In the ‘treasure’ of the expression of problematic mental health conditions, the consumer holds the trump card for the entire sector—for stakeholders interested in community protection, and for those interested in proper consumer care, alike. Whether expressed in the form of non-compliance, repeated visits to expensive services, civil disruption, violence or just confronting unwellness—almost literally, no one wants to see it. Other stakeholders are prepared, in fact, to ‘pay’ to avoid seeing it. But consumers don’t want to ‘spend’ this mental (ill-) health capital because by doing so all of their values and interests are compromised, stigma is reinforced, and their own identities further damaged.

Overall, and whether it is actually or only threatened to be spent, the expression of poor mental health can and does significantly influence policy outcomes. Consumers could strategise to leverage this ‘treasure’ more effectively, although increase in their capacity under one or more of the other heads (such as ‘organisation’) would likely be necessary to achieve this. It is possible also that the balance of stakeholders could arrange to ‘purchase’ the dissolution of the capital by providing better access to mental health services.

The effective reduction of mental ill-health in the community would meet almost all of the stakeholders’ objectives. It is the holy grail of policy outcomes for the sector. Until this happens, however, consumers retain great regulatory capacity in the domain in the centrality of their unwellness, despite that this capacity is currently under-exploited in both its positive and negative expressions.
Community
The overall medium rating for the influence of the community stakeholder is a function of low capacity on all heads except for its ‘treasure’, electoral power. The literature shows that the state does attend to the tenor of public view in mental health matters, where that view is clear. Often, however, this is not the case. The community’s ambivalent attitudes on mental health, and towards those with mental health conditions, was demonstrated in the review literature, though the value of personal security did seem favoured on balance. This suggests that the regulatory capacity of the community could be significantly increased if it demonstrated stronger, more consistent attitudes.

The media plays a significant role in moulding community attitudes. The analysis suggests that the powers of the media could potentially be harnessed to shift community attitudes towards a better access to service for consumers, if the relation between better access and the amelioration of the community’s personal security concerns was made clear.

State
On 7 February 2013, the then newly-released Francis report on the NHS detailed “appalling and unnecessary suffering” for patients in a system “which ignored the warning signs and put corporate self-interest and cost-control ahead of patients and their safety” (Campbell, 2013, para. 11). The review literature demonstrated a similar order of priorities for the state in the mental health sector: first, cost containment; secondly, community safety; and thirdly, care and treatment. The state rated highly under all heads of regulatory capacity except for ‘organisation’. The many iterations of the state in its various agencies and units undermine its capacity to develop and implement cohesive policy. Its control over funding is another trump card in the sector—this time, fully exploited.

Public psychiatrist
The voice of the much-reduced public psychiatrist arose strongly in the review. Psychiatrists see themselves as losing influence in the sector—and this perception is supported by the literature. Now relatively removed from the ‘mental health conversation’ and despite energised advocacy by individual psychiatrists, as a class they have low ‘nodality’. The ‘authority’ of their professionalism has wilted in a managerialist, risk-focussed public mental health system. They have arguably the lowest, actualised ‘treasure’ of the four reviewed stakeholders, with their expertise in fixing poor mental health currently devalued and re-directed to risk assessment exercises or not exercised for fear of blame; and their responsibility for adverse events a ‘treasure’ they do not happily accrue. This is not beyond
remediation however. I have interpreted a marginal high for ‘organisation’ for psychiatrists as the college system signals potential, at least, for the marshalled, focussed and influential expression of their interests. This capacity is almost entirely unexploited however with the professional collegiate view fragmented, and the voice itself almost entirely absent from public debate.

3.6.3 RELATIVE STRENGTH OF THE 'ACCESS' INTEREST

A relatively low priority for a powerful stakeholder
In the push-pull of influential capacities between the various stakeholders in the mental health policy domain, there is no doubt that the access objective, registering as at least part of the interests of all four stakeholders, is one of the principal concerns within the domain overall. Applying the ‘public choice’, market-based model of interest and influence that underpins the network governance perspective, access to service may be considered a substantial object of trade in the economy of influence in the sector, and amenable (and also vulnerable), to change in value. But the theory of regulatory capacity holds that, where competing interests in a policy domain conflict, the interests of stakeholders with the most influential capacity are likely to be favoured by policy (C. Scott & Brown, 2010). Because of its salience for the actor with the highest regulatory capacity, the state—for which access rates considerably below both cost containment and community protection in the order of its interests—the current value of the access objective in the policy domain overall is rated, therefore, ‘low-to-medium’.

Access may improve if regulatory potential actualises
This characterisation highlights the importance of the difference between expressed and potential regulatory capacity. The results suggest that the consumer stakeholder is constrained by agenda identity factors from prosecuting the potential of its ‘treasure’ of mental ill-health. The community’s use of its considerable electoral capital is constrained by its own ambivalence. The psychiatrists’ use of their potentially strong professional organisational capacity is hampered by a fragmented and deflated membership. The access objective is a highly salient interest for each of these three actors who have much greater potential influence than they currently deploy. The access to service objective is, potentially then, a much more salient objective than it currently represents.
3.7 CONCLUSION

The Phase II Network governance study investigated the interests in play, and the nature and strength of the respective regulatory capacities possessed by principal actors within the mental health law and access domain. Specifically, the study sought to identify:

- What characteristics of each actor affect its capacity to influence outcomes in the sector in the direction of their interests?
- What are the regulatory capacities of each actor relative to each other?
- How do the actors’ principal interests, values, and culture affect the exercise of its regulatory capacity?
- What is the salience of the interest ‘access to mental health services’ relative to other operative interests within the domain?

Method and limitations

The research questions were investigated employing a modified version of the critical interpretive synthesis literature review method (Dixon-Woods, 2006) interpreted through the filter of the NATO framework of elements of regulatory capacity (C. Scott & Brown, 2010).

The principal limitation of the study was the absence of a method of triangulation of the results, including the interpretive muscle of a larger research team.

With more research resources (human and time) to manage the sampling frame, the period of the literature review might have been usefully extended to two rather than the one decade officially the period of the review. Most of the debates and issues identified in the literature have auspices reaching back to the early 1990s at least. The narrower time-frame created the need to admit anomalous high relevance items outside the stated period to enable saturated coverage of particular themes.

Summary of results

Results in relation to research questions 1-3 are summarised in Table 6.

The results of the Phase II study of the mental health law and access domain reflect the micro-economic origins of the network governance approach. Each stakeholder in the mental health and access domain can be seen to move within the system with specific strengths and weaknesses, with specific needs, priorities and characteristics. The regulatory capital or ‘treasure’ possessed by each actor is a form of currency, invested profitably or otherwise, according to the interests of actor.
Specifically, theory developed from the study:

- confirms the membership of each of the four stakeholders in the mental health domain;
- characterises the elements of regulatory capacity and agenda identity of each of the four stakeholders, as summarised in Table 6;
- suggests that the actualised regulatory capacity of three of the four domain members studied (consumer, community and psychiatrists) is significantly lower than their potential, unexploited regulatory capacity;
- orders the overall regulatory capacity of the state at the highest amongst the four stakeholders, with the balance of the three similarly to each other;
- suggests that the actualised regulatory capacity of three of the four domain members studied (consumer, community and psychiatrists) is significantly lower than their potential, unexploited regulatory capacity, and
- suggests that access to service has relatively low salience as an objective within the domain overall.

**Actualised v. potential regulatory capacity**

The identification of a difference between actual and potential regulatory capacity in the mental health and access domain was an unexpected and interesting outcome from the study. To reiterate, it was found that each of the consumer, community and psychiatrist stakeholders possess regulatory capital potentiated for more significant influence than other inhibitory, regulatory characteristics and conditions within the domain currently permit. Table 7 provides details of the principal ‘treasure’ identified for each of these underperforming actors, and the factors identified as constraining the performance of its investment.
Table 7
Unexploited regulatory capital in the mental health law and access domain

<table>
<thead>
<tr>
<th></th>
<th>Principal regulatory capital</th>
<th>Inhibiting factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>Professional expertise.</td>
<td>Much reduced clinical authority.</td>
</tr>
<tr>
<td></td>
<td>Preparedness to take</td>
<td>Unexploited organisational capacity.</td>
</tr>
<tr>
<td></td>
<td>responsibility for</td>
<td>Poor public relations.</td>
</tr>
<tr>
<td></td>
<td>risk management and outcomes.</td>
<td>Pervasive despair.</td>
</tr>
<tr>
<td>Community</td>
<td>Electoral power.</td>
<td>Ambivalence</td>
</tr>
<tr>
<td>Consumer</td>
<td>Mental ill-health.</td>
<td>Expression constrained by policy.</td>
</tr>
</tbody>
</table>

There are two issues of note here. First, it appears that the possession of regulatory capital, or ‘treasure’, appears to be a condition not readily amenable to change, part of the genotype of a stakeholder’s capacity to influence. Secondly, and by contrast, the inhibitory factors, arising from heads of regulatory capacity other than ‘treasure’—being ‘nodality’, ‘authority’ and ‘organisation’—are more permeable conditions, amenable to change through policy interventions or other changes determined by the stakeholder itself.

The ascendancy of the state: not so effective, not so strategic?
That the state was found, by some distance, to possess the highest regulatory capacity within the domain might not seem surprising. There is dubious wisdom in maintaining this position however—from the point of view of the state’s own, let alone other stakeholder’s, interests. Neo-liberalism, with its emphasis on the contraction of government, self-regulation and marketisation, encourages more creative approaches to governance, especially within an arguably failing policy sphere such as the mental health sector. The strategic value, for the state, of retaining such an outstandingly strong role is questionable.

Salience of the ‘access to service’ objective
The salience of the interest ‘access to service’ was found to be relatively high for each of the consumer, community and psychiatrist stakeholders. In terms of its salience, overall, however, it was argued that ‘salience follows actualised capacity to influence’ and as such, that the salience of access for the domain as a whole must be relatively low, reflecting its priority, as interpreted, for the stakeholder with the most outstanding capacity, the state. It is noted, however, that this level of salience for the access objective could change, along with the relative regulatory strength of the non-state actors, if the inhibiting factors referred to previously were removed.
Policy implications
What can be taken from the Phase II study as a measure of the health of the system as a whole? What might be considered the ‘GDP’ of the mental health policy domain and how might it be improved? These reform-oriented questions lead immediately to the normative issues around ‘what works’ and from whose perspective. But staying with the global gaze, invited through the meta-regulatory lens, it is clear that the reduction of the consumer’s unenviable ‘treasure’ of mental ill-health, would be valued across the domain. It would be a true win-win (-win-win…) solution for all parties. The results of the Phase II study do suggest that getting to this outcome, to attend in some measure to the interests of all stakeholders, would require the tweaking—indeed, the tugging—of policy threads towards enhancement of the actualised regulatory capacity of stakeholders for whom the access to service objective has more salience, while also managing the state’s prime interests of cost-control and the abatement of the ‘fear of risk’.
These minor engagements do not have the arrogance of programmatic politics—perhaps they even refuse their designation as politics at all. They are cautious, modest, pragmatic, experimental, stuttering, tentative. They are concerned with the here and now, not with some fantasized future, with small concerns, petty details, the everyday and not the transcendental. They frequently arise in ‘cramped spaces’—with a set of relations that are intolerable, where movement is impossible, where change is blocked and voice is strangulated. And, in relations to these little territories of the everyday, they seek to engender a small reworking of their own spaces of action.

(Rose, 1999, p. 279-280)

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4.1 INTRODUCTION

Research questions reprised

This Chapter addresses the findings of the Phase III realist governmentality sub-study in relation to both the principal and preliminary research questions outlined previously at sub-section 2.6.4 Research questions and limitations.

Principal research questions:

- How is risk-based mental health law deployed within assemblages of power relations involving public psychiatrists?
- How does this functioning affect access to service?

Preliminary questions:

- What are the operative problematisations, rationalities, strategies (including vectors of influence) and technologies of power in each relevant assemblage?
- What objectives of the influencer may be inferred from the operative strategies and technologies in each assemblage? How do these compare with expressed rationalities?
- How does a vector of influence affect the action generated by the subject? On themselves? On other stakeholders in the domain? How does this action relate to the intentions of the influencer?

The results summary

Summaries of the results relating to the preliminary questions addressing the genealogy of the assemblages of power relations involving public psychiatrists are set out in the form of assemblage diagrams at the beginning of section 4.2 Assemblage A1a: State to Psychiatrists, and sub-sections 4.3.1 Assemblage A1b: Psychiatrists to the State and at 4.3.2 Assemblage A2a: Psychiatrists to Consumers in this Chapter. These summaries include all governmental relations indicated by data from the Phase III sub-study—not just those elements that specifically implicate mental health law or access.

These summaries, and the text of these findings, refer to results relating to the elements of governmentality assemblage generically described in sub-section 2.6.1 Elements of governmentality assemblage. These include: rationality, strategy, vector of influence, technology of power and the response of the subject.

The responses of the subject have been divided into action directed inwards, on the self of the stakeholder, and action directed externally, from the self stakeholder.
Furthermore, and as a product of the focus identified at sub-section 2.6.3 Other specific analytic focii to distinguish evidence of Dean’s ‘inconvenient facts’, findings in relation to an agenda on the part of a stakeholder that is not reflected in its published rationale for policy interventions, are recorded under the generic heading ‘additional objectives’, and are grouped with the rationalities under the head ‘Policy Drivers’.

In early versions of the full assemblage diagrams I attempted to represent horizontal ‘lines of force’ (Newman & Clarke, 2009) connecting specific vertical elements. Progressively, however, the links became so multitudinous that visual representation lost meaning (though the notion of an assemblage as a web of intertwining power relations was more than adequately demonstrated). Important specific linkages between elements are nonetheless addressed visually, in sub-set assemblage diagrams, and in the Chapter text.

**Assemblages reported**

It is noted that the data gathered in the sub-study related most particularly to relations in Assemblage A1 (The State and Psychiatrists), with somewhat less to those in Assemblage A2 (Consumers and Psychiatrists). There was little research product arising in relation to the dyad of relations at Assemblage A3 (Community and Psychiatrists). The results for Assemblages A3a&b and A2b (Consumers to Psychiatrists), though forming an important part of the fabric of governmentality relations overall, did not bear direct relevance to the principal research questions, and, thus, are reported in Appendix B to this thesis. This Chapter reports findings, therefore, only in relation to Assemblages A1a, A1b and A2a.

**Informant account excerpts: de-identification strategy**

The findings of the study are supported, at numerous places in this Chapter, by sample extracts from informant interviews. Initially, these extracts were identified with ‘tags’ for the informant’s pseudonym, role description, and age range. It became apparent, however, that this combination of descriptors could lead to identification of subject informants, particularly if a reader sought to match comments attributed to the same pseudonym. Despite my concern to demonstrate credibility, I have conceded the greater importance of de-identification, particularly in the politically-sensitive context of many of the comments reported, and the drastic possible consequences for informants. I decided, firstly, to delete the role identification, and then, finally, the pseudonym itself.

There were points, however, where the age and sex of the informant featured in analysis. These differentiators were retained.
4.2 ASSEMBLAGE A1A: STATE TO PSYCHIATRISTS

The major elements of the findings of the Phase III sub-study in relation to Assemblage A1a: The State to Psychiatrists are summarised in Figure 3.

As Figure 3 depicts, there are a number of technologies of power exercised by the state, and a number of responses by psychiatrists, that do not engage mental health law. These products of analysis, as they do not relate to the principal research questions of the Phase III sub-study, are summarised in Appendix C to this thesis.

In this section of this thesis, I report and discuss the results focussing on the elements of Assemblage A1a that engage mental health law, either in the expression of influence on the governing side, or in response to it.

I attend, firstly, in ‘technologies of power’, to evidence of the state’s exercise of regulatory influence in practice and in discourse. The study identified five principal technologies of power engaged by the state to influence public psychiatrists. These included:

- the technology of employment;
- a range of accountability processes;
- certain accompanying ‘technologies-of-the-self’;
- the common law, and
- mental health law.

The technologies identified were found to convey six ‘vectors of influence’ across the assemblage:

- responsibilisation for compulsory treatment and detention;
- a ‘risk takes priority’ discourse;
- de-professionalisation;
- a ‘manage scarce resources’ discourse,
- a ‘minimise perception of service limitations’ discourse, and
- blame.

The legal technologies were found to convey only the first two vectors of influence:
‘responsibilisation’ and the ‘risk takes priority’ discourse.

From the logic of findings in relation to technologies of power, the state’s strategies of influence, and the rationalities and additional objectives that fuel and motivate them were inferred.

Finally, I report and discuss results in relation to public psychiatrists’ responses to the state’s expressions of influence in the form of ‘actions externally’ and ‘actions-on-the-self’.
The genealogy of Assemblage A1a: The State to Psychiatrists

Figure 3
4.2.1 TECHNOLOGIES OF POWER: THE LAW

The Phase III sub-study found that two vectors of influence, ‘responsibility for compulsory treatment and detention’ and the ‘prioritise risk’ discourse, were transmitted by either or both of the technologies of mental health law and the common law, across the A1a governmentality assemblage.

4.2.1.1 ‘PRIORITISE RISK’ DISCOURSE

Response data from the Phase III sub-study strongly suggest that publicly-employed psychiatrists are subject to pressure from the state to prioritise the provision of care to patients assessed to be at risk of causing harm. This influence is conveyed by the state to public psychiatrists through the operation of the technology of mental health law working in tandem with the technology of employment:
Well, [my aim] would be to help people in hospital until you actually take care of the symptoms well enough, rather than just have them patched up well enough to get them out. That is what it is set up for, the hospital. Generally those things take precedence over traditional clinician's values.

Discourse analysis of clinical guidelines and other state documentation showed that the risk priority is promoted by conflation of the concepts of risk and clinical need. The following excerpts from NSW Clinical Risk Assessment and Management Guidelines demonstrate the state’s determination to draw risk and clinical need into a single conceptualisation:

A risk management plan can be seen as the “treatment” for the “condition”
(risk of violence/aggression)

(Allnutt, O'Driscoll, Ogloff, Dafer, & Adams, 2010, p. 35)

The real usefulness of the PCL-R, and construct of Psychopathy in mental health, comes from its association with increased risk of violence and prediction of poor response to rehabilitation

(Allnutt et al., 2010, p. 15)

The valorisation of risk continues within the legal discourse of mental health law. The model of regulatory technology comprised in the mental health law of all the Phase III jurisdictions describes a system of compulsory treatment based on risk. Analysis of the Phase III Acts included analysis of mental health law content by theme, with results as summarised in Table 8.
Strikingly, fully 56 per cent of the overall number of sections describe and establish process surrounding enforceable court orders for involuntary treatment and detention. By comparison, merely 1 per cent of provisions deal with facilitation of service to voluntary patients, and, despite the strength of the rhetoric contained in the Objects clauses, only 6 per cent of total content addresses rights and protections for consumers.

This analysis of Australian mental health law instrumentation suggests that the state is very, if not mostly, concerned to ensure its capacity for involuntary treatment and control of consumers. It also points to a distinct policy choice to favour the provision of public mental health services to low-prevalence, acute, high-risk adult patients.

This discourse, that ‘the highest risk patients have the highest priority for service’, has been recognised in the literature. Bernadette McSherry (2008) refers to findings of the numerous inquiries into the Australian mental health system to support her conclusion that the traditional focus of mental health laws on the treatment and detention of those with low-

### Table 8

**Content of Phase III Acts by theme**

<table>
<thead>
<tr>
<th>Content themes</th>
<th>n of statutory sections by theme (Total n=1,144)</th>
<th>% of overall content by theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Involuntary patients</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orders</td>
<td>202</td>
<td>18</td>
</tr>
<tr>
<td>Apprehension/Transport/Interstate Treatment</td>
<td>91</td>
<td>8</td>
</tr>
<tr>
<td>Treatment</td>
<td>116</td>
<td>10</td>
</tr>
<tr>
<td>Security and forensic patients</td>
<td>97</td>
<td>8</td>
</tr>
<tr>
<td>Tribunal</td>
<td>135</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>641</td>
<td>56</td>
</tr>
<tr>
<td><strong>Miscellaneous and preliminary provisions</strong></td>
<td>251</td>
<td>22</td>
</tr>
<tr>
<td><strong>Administration</strong></td>
<td>138</td>
<td>12</td>
</tr>
<tr>
<td><strong>Rights and protections</strong></td>
<td>71</td>
<td>6</td>
</tr>
<tr>
<td><strong>Complaints</strong></td>
<td>43</td>
<td>4</td>
</tr>
<tr>
<td><strong>Privacy and information</strong></td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td><strong>Voluntary patients</strong></td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td><strong>Carers</strong></td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

*Source: Mental Health Act 2007 (NSW); Mental Health Act 2014 (Victoria); Mental Health Act 2013 (Tasmania); Mental Health Act 2009 (SA) and Mental Health (Treatment and Care) Act 1994 (ACT)*
prevalence serious mental illnesses has skewed the allocation of resources so as to obstruct satisfaction of the right to service for all individuals with mental illnesses, including the high-incidence disorders of depression and anxiety.

The existence of a ‘prioritise risk’ discourse is further supported by the design of the risk-of-harm criteria for activation of the compulsory treatment provisions at the core of the Phase III mental health legislation. The risk-of-harm criteria in all of the Phase III jurisdictions mental health laws is set out, in precis, at Table 1 (section 1.3 The role of mental health law). It is clear from these terms that, notwithstanding whatever other intents are actually or ostensibly served—such as protection of the rights of consumers—the risk-of-harm criteria in mental health law distinctly support provision of treatment to high-risk patients.

### 4.2.1.2 RESPONSIBILITY FOR COMPULSORY TREATMENT

As expected, the Phase III sub-study results demonstrated that public psychiatrists are subject to state influence to take responsibility for compulsory treatment and detention. This influence is conveyed through the operation of the technologies of the common law, mental health law and the technology of employment, in tandem. A persistent theme, arising both in the fieldwork and in discourse analysis, is whether this ‘responsibilisation’ merely empowers, or rather obliges, the exercise of powers to compulsorily treat and detain.

**Perceptions about duty of care**

Whatever its basis in fact, many psychiatrists are concerned that either or both mental health law and the common law conveys a duty on psychiatrists to exercise their statutory powers. This understanding operates as a significant regulatory influence in itself:

Informant: I guess we are obliged to accept people who we think would meet the criteria for involuntary treatment...

Interviewer: Do you think there are others who should take the criteria as obligatory in that way also?

Informant: They have to by law. This is the requirement.

[Male, 41-55]

I think the real worry is because of...there are some other factors like litigation, and also the scrutiny....the community, and especially the legal system. So clinicians are sometimes, you know, worried about managing somebody in a certain way...because of fear of litigation.

[Male, 40-54]
What does the psychiatrists’ common law duty of care cover?
Whether psychiatrists have powers or duties in relation to compulsory treatment and detention involves a complex and evolving matrix of legal variables.

Like other medical practitioners in Australia, psychiatrists have an inherent duty of care to exercise reasonable care and skill in the provision of medical treatment: Rogers v. Whitaker (1992). The composition of that standard is still mobile however. In Rogers v Whitaker (1992), the court held that the applicable standard of care in the circumstances was to be decided by the court. Since that case, civil liability law has been enacted to specifically align the standard applying legally with medical professional opinion in all of the Phase III jurisdictions except the Australian Capital Territory, where the common law still applies. These new ‘black letter’ laws align the legal standard of care with professional opinion. Under these laws, doctors are protected from liability if their treatment decision would be widely accepted in Australia by peer professional opinion, and provided that that opinion as applied in the circumstances would not be irrational (NSW) or unreasonable (Victoria).

Despite this, there is additional case law that explores whether public psychiatrists’ common law duty of care, as adjusted by the civil liability laws, requires the exercise of their statutory powers under mental health law to compulsorily treat and detain. The results in important recent cases are distinguished, respectively, by whether the alleged duty relates to the consumer or to a third party suffering harm, by jurisdiction (the wording of statutes differ in each state-level jurisdiction), and by the particular factual circumstances in each.

Does ‘responsibilisation’ include a duty to exercise statutory powers?
The trajectory of current authorities commences with Crimmins v. Stevedoring Industry Finance Committee (1999) in which McHugh J articulated a six-question test for the existence of a (common law) duty of care to exercise a statutory duty (a duty established by a parliament-made law). Subsequently, in Presland v. Hunter Area Health Service (2003), a modified version of the six-question test was applied to determine whether there is a duty of care to the consumer to exercise compulsory treatment and detention powers in the NSW Mental Health Act in certain circumstances. As a result, in Presland, a consumer who had been convicted of homicide after discharge from a mental health unit initially succeeded in a damages claim against the service responsible for his discharge from compulsory care. The decision was

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14 see s. 50, Civil Liability Act 2002 (NSW); s. 41, Civil Liability Act 1936 (SA); s. 22, Civil Liability Act 2002 (Tas); s. 59, Wrongs Act 1958 (Victoria)
reversed on appeal by the full court, but only on the basis that the type of damage claimed by the consumer, being lawful incarceration for the homicide, made no legal sense as a form of damage founding a negligence claim, rather than because no duty was found: *Hunter Area Health Service v Presland* (2005).

Testing for the existence of a common law duty to exercise statutory powers continued in a number of contexts. In *Stuart v Kirkland-Veenstra* (2009) it was decided that police officers attending a suicidal man were not under a duty to use powers of apprehension under mental health law, but the case was distinguished by the view that the mental illness of the suicidal man had not been established. Then in *Crowley v. Commonwealth of Australia, Australian Capital Territory and Pitkethly* (2011), the trial judge, though noting the original *Presland* judgement with approval, found it unnecessary to decide whether the duty existed on the particular facts of the case. But she also identified a complexity in the exercise of such a duty, if it existed, alongside the requirement to ensure the “least restrictive form of treatment” as required by the mental health law. In the same matter, on appeal, the full court found there was not the requisite doctor-patient relationship to found a duty of care, but that even if there was one, and a duty of care existed, the duty did not include a requirement to exercise the compulsory powers: *ACT v. Crowley* (2012).

By contrast, in another mental health service and homicide case, *McKenna v. Hunter & New England Local Health District* (2013), it was the trial judge who found that there was no breach of a duty of care to exercise compulsory treatment powers, with his decision then reversed in the NSW Court of Appeal, which confirmed causation, the existence of a duty, and a breach of that duty by the mental health service, which again had discharged a consumer who subsequently committed a homicide. The matter was appealed then in the High Court, which, in late 2014, held that a duty of care to third parties to exercise statutory powers to treat and detain would be inconsistent with the requirement, under mental health law, that compulsory powers must not be exercised against a consumer unless they constitute the least restrictive form of treatment available.

Thus, it has been finally decided that there is no common law duty to exercise statutory powers to compulsorily treat and detain, at least in relation to third parties and to New South Wales mental health legislation is it currently stands.

**Remaining exposures for psychiatrists and the services**

The High Court’s decision in *McKenna* does not determine the existence (or not) of a common law duty of care to the consumer to exercise statutory powers under mental health
law, or whether mental health law establishes a statutory duty\textsuperscript{15} for the exercise of compulsory treatment and care powers \cite{HunterNewEnglandElizabethMcKenna}(2014), para. 12).

\textbf{4.2.2 STRATEGIES}

While the focus of the previous section centred on the mechanics of the expression of influence by technologies, it also identified elements of influence exerted by their use. These expressions, referred to as vectors of influence, often engaged more than one technology for their transmission from one side of the governmental relationship to the other. In this sub-section, we consider what strategies of government might be inferred from those tangles of practice and discourse.

As explicated in Chapter 2, the vector of influence is not classified separately in the generic taxonomy of governmentality assemblage elements as it has no independent function. Rather, it is an element of governmental strategy. The empirical identification of vectors of influence founds inference of broader strategic planning, whilst being inseparably part of it. Strategies are \textit{nests} of such vectors and their associated technologies, and may involve actors other than the stakeholders identified for empirical attention.

As Figure 3 shows, the Phase III sub-study identified five specific governmental strategies of the state, including strategies addressed to cost minimisation, electoral concerns, adverse events (2), and access.

\textbf{A minimise cost strategy}
Most straightforwardly, the logic of the ‘manage scarce resources’ discourse suggests a major state strategy to ‘provide service at minimal cost’.

\textbf{An electoral strategy}
Also clear, the evidence for the ‘support and protect the service’ discourse suggests a strategy to ‘minimise public dissatisfaction with access or the quality of service’.

\textbf{Adverse events strategy}
Taken together, the workings of the blame vector, the ‘responsibilisation’ vector and the \textsuperscript{15}A statutory duty arises by the construction and interpretation of parliament-made law and could apply \textit{in addition to} any common law duties of care.
‘prioritise risk’ vector point to a strategy to ‘minimise the incidence of adverse events’.

Additionally, the vectors of blame, responsibilisation and ‘support and protect the service’ together suggest strategic concern not just to minimise adverse events, but to ‘shift responsibility for adverse events (away from the state)’.

Informant: I think it’s a strange combination here as the service is very risk-averse in many ways. And yet, putting lots of pressure on you to take risks.

Interviewer: To take professional risks?

Informant: To move people on -

Interviewer: And the burden is felt by the clinician?

Informant: Without the power to address that, honestly. I think that’s the problem. We are kind of left quite exposed.

[Male, 25-40]

In this excerpt, this informant reflects on a significant paradox revealed by the Phase III sub-study—namely, that public psychiatrists are pressured to support and protect their employer services from blame and criticism for adverse events precisely by absorbing it themselves! The same irony is recognised by Szmukler and Rose, who suggest that while services themselves are ostensibly highly risk-averse, they ask their employee clinicians to assume vast risk, to “do what is impossible—to accurately predict and subsequently to prevent rare episodes of serious violence” (Szmukler & Rose, 2013, p. 137).

A ‘limited access for high-risk consumers’ strategy

The interplay of identified vectors suggests an overall strategy in relation to access and servicing that is played-out with subtlety. Again, the intensity and variety in technological expressions of the responsibilisation of psychiatrists for compulsory treatment and containment is notable, suggesting significant governmental concern to retain physical and medical control of the consumer.

Considered in the light of the ‘prioritise risk’ discourse, this clarifies to a particular focus to control and treat high-risk consumers. Considered in the light of fiscal concerns (generating the ‘manage scarce resources’ discourse), and the electoral concerns of the ‘align with the service’ discourse, as well as the blame and responsibilisation expressions, a strategy may be inferred of providing only so much service as is necessary to manage public expectations about service, and about living safely. The overarching strategy here may be summarised: ‘to provide limited access to mental health services for the highest-risk consumers’.
Where does de-professionalisation fit?
The view to the strategy behind the ‘de-professionalisation’ vector is more opaque, or at least multi-layered. On the one hand, de-professionalisation practices might be seen to represent the firmer regulatory position of the state in relation to the role and duties of public psychiatrists, resulting from the community’s perception of the disaster of historical excesses of psychiatric autonomy, such as the Chelmsford institutional tragedy in Australia, and other execrable practices around asylum (Lupton, 1993). On another hand, or additionally, the de-professionalisation practice and discourse identified in Phase III might be viewed as part of the rise of managerialism, reflecting the flattening of clinical authority in public health services across the neoliberal world (Barnes & Prior, 2009; Carney, 2008; Doessel, Williams, & Whiteford, 2009; Waring, 2007).

That de-professionalisation in the Australian context at least appears to occur alongside the rise of other much cheaper human resources, such as nurses and non-clinical managers, suggests that the managerial imperative of cost control is indeed a powerful driver for this line of policy in the Phase III jurisdictions.

The essence of the vector, however, appears to be about constraining the autonomous decision-making of the psychiatrist whilst—again, paradoxically—ensuring that the psychiatrist remains principally responsible for the decision. Alternative agents, such as nurses and non-clinical managers, who now have more input into decisions, are seen to have values more aligned to the organisation, whereas psychiatrists remain fatally aligned with the interests of their patients. It seems likely, then, that de-professionalisation is also another vector of the strategy to ensure state control over who gets treated and how—that is, as part of the ‘limited access for high-risk consumers’ strategy described above.

Summary
The state’s strategies-in-action empirically identified in Phase III analysis and their composite vectors of influence are summarised in Table 9.
Table 9

*Governmental strategies of the state and their composite vectors of influence as directed to public psychiatrists.*

<table>
<thead>
<tr>
<th>Governmental strategy</th>
<th>Vectors of influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimise public dissatisfaction with access or the quality of service</td>
<td>‘Align with the service’</td>
</tr>
<tr>
<td>Minimise cost</td>
<td>‘Manage scarce resources’</td>
</tr>
<tr>
<td></td>
<td>‘Prioritise risk’</td>
</tr>
<tr>
<td></td>
<td>De-professionalisation</td>
</tr>
<tr>
<td>Minimise the incidence of adverse events</td>
<td>Blame</td>
</tr>
<tr>
<td></td>
<td>‘Responsibilisation for compulsory treatment and control’</td>
</tr>
<tr>
<td></td>
<td>‘Prioritise risk’</td>
</tr>
<tr>
<td>Shift responsibility from the state for adverse events</td>
<td>Accountability</td>
</tr>
<tr>
<td></td>
<td>Responsibilisation for compulsory treatment and detention</td>
</tr>
<tr>
<td></td>
<td>Blame</td>
</tr>
<tr>
<td>Provide limited access to mental health services for the highest-risk consumers</td>
<td>Responsibilisation for compulsory treatment and detention</td>
</tr>
<tr>
<td></td>
<td>‘Prioritise risk’</td>
</tr>
<tr>
<td></td>
<td>‘Manage scarce resources’</td>
</tr>
<tr>
<td></td>
<td>‘Support and protect the service’</td>
</tr>
<tr>
<td></td>
<td>Blame</td>
</tr>
<tr>
<td></td>
<td>De-professionalisation</td>
</tr>
</tbody>
</table>

The strategies of government are ordinarily expected to programme achievement of the rationale for policy interventions—that is, of genuine policy goals. The content of governmental strategies as inferred within the Phase III sub-study, however, suggests specific and *alternative* policy objectives. Before considering what these might be, it is useful firstly to examine the rationalities of policy expressly advanced.
4.2.3 RATIONALITIES OF MENTAL HEALTH LAW

I have outlined previously how published statements of government (termed ‘rationalities’), representing at least the declared portions of the mental health policy of the state, may be engaged to provide normative impetus for strategies of regulatory influence exercised by the state on public psychiatrists.\(^\text{16}\) This sub-section attends to the content of such rationalities, with particular focus on those formed in and by mental health legislation.

In the discourse analysis stage of the Phase III methodology, the Phase III Acts (mental health laws of the five relevant jurisdictions\(^\text{17}\)) were analysed for their expression of state rationalities, in addition to other items of state mental health and mental health servicing policy.

What is a rationality?

As explicated previously, within the governmentality conceptualisation, the rationality of an influencer is a truth claim or moralisation embedded in oral or written discourse that may relate to perceived problem of governance (Foucault, 2003f). This truth claim authorises and energises certain regimes of practice and discourse in the form of technologies of power.\(^\text{18}\)

The rationalities in mental health law

As is common in Australian legislation, each of the Phase III Acts has a ‘purpose’ or ‘objects’ clause. A purpose clause is included by the legislature as an aid to statutory interpretation—for actors and for the courts alike—and as an explication of the intentions for the law, of the outcomes it is intended to achieve, and of the fundamental policy aims that underpin its enactment (Pearce & Geddes, 2014). It is within this set of provisions within each Act that the most explicit statements of governmental rationality—signposts to the “will of the legislator” (Crennan, 2010, p. 3)—are likely to be found.

A summary of the various ‘objects’ of the respective Phase III Acts is set out at Figure 3. Analysis revealed a great deal of consistency in the expressed objectives of the Phase III laws, making them amenable to grouping by theme. The four principal themes identified were: provision of treatment and care, protection of the rights of consumers, protection of

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\(^{16}\) Refer to sub-section 2.6.1 Elements of governmentality assemblage.

\(^{17}\) Refer to sub-section 2.6.13 Legal discourse analysis.

\(^{18}\) This dynamic describes Foucault’s ‘knowledge/power nexus’ (Foucault, 2003d, 2003f).
the community, and a miscellaneous group. This grouping of themes is not at all surprising, relating closely in type to Baroness Hale’s classification of mental health law’s “overlapping but often competing goals: protecting the public, obtaining access to the services people need and safeguarding user’s civil rights” (Hale, 2007, p. 19).

The moralisations or assumed truths embedded in these objectives include that we should, as a society, facilitate access to treatment for mental illness and disorder; that consumers’ human rights should be actively protected; and that the community should be protected from the harm that is potentiated by mental illness and disorder. These norms relate directly to established problematisations, or at least to taken-for-granted assumptions, about the need for state intervention to ensure treatment for mental illness, rights protection, and for protection of society from harm caused by people with mental health conditions.

**Rationalities receive variable emphasis**

But it appears that not all rationalities are created equally. Analysis indicated strikingly different levels of emphasis afforded to the four respective rationality themes within the objectives stated for the Phase III jurisdictions’ laws. The highest number of references to an objective or purpose belonged to the ‘protection of consumer rights’ theme group, with 17 separate references to rights-based objectives, across the Acts of all five jurisdictions. Closely following this, there were 16 separate references, again across all five laws, to provision of ‘treatment and care’.

Analysis of the particular privileging of consumer rights in the objects of the Phase III jurisdiction Acts accords with the emphasis afforded to rights issues in other items of state discourse surrounding the various Acts. The following statement of the purpose from the South Australia Health webpage clearly valorises the rights facilitation rationale:

> The Mental Health Act 2009 provides South Australia with an improved legislative framework that sets out the rights of people with mental illness and assists with their recovery and participation in community life [emphasis added].

*(SA Health, 2014 para. 1)*

Similarly, in Victoria:
This document presents the major reforms that the government intends to incorporate in Victoria’s new mental health policy framework. At the heart of these reforms is a supported decision-making model of treatment and care. The new legislation will promote recovery-oriented practice through the establishment of various mechanisms that will facilitate strong partnerships between patients and practitioners [emphasis added].

(Wooldridge, 2012, Foreword)

By contrast, and somewhat surprisingly, there were only four references, in the objects, and in only four out of the five Phase III Acts, to ‘protection of society’.

**Emphasis on respective rationalities v. the content of legislation**

The difference in respective emphasis afforded to each of the stated rationalities for mental health law in legal and other discourse suggests a particular order of priorities—that the state is primarily concerned with protecting the rights of consumers and providing them with treatment and care, with ‘protection of the community’ a rather distant third consideration.

Yet the respective emphasis on the ostensible purposes of the legislation contrasts starkly with the amount of content devoted to these themes respectively. As noted previously, the study found that only 6 per cent of the total content of the Phase III Acts promotes the most prominent rationality—rights and protections for consumers—while fully 56 per cent of the content instrumentalises involuntary treatment and detention.

Whilst not too long a bow can be drawn from word counts alone, such a disparity is significant. It is difficult to avoid the conclusion that the rationalities established for the Phase III jurisdictions’ mental health law are set up to function as engines of moral- or knowledge-power, rather than the representing the true objectives of the state. The rights rationality has the highest moral and political appeal, and so is vaunted at the forefront of the law, framing public consciousness and support for the intervention. It is not beside the point that the machinery of the law, in fact, achieves something very different indeed.

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**4.2.4 ADDITIONAL OBJECTIVES**

The previous sub-section identified three rationalities, ostensibly representing the foundations of mental health regulatory policy as reflected in mental health law: to protect the rights of consumers, to provide them with treatment and care, and to protect society from high-risk consumers.
As argued previously, it is only through analysis of the logic and affinity between these rationalities, and the strategies and technologies of the state ‘in action’ in the field, that the full and operative agenda of the state can be discerned (Dean, 2009; Fairbanks II, 2008; Gordon, 1991). Using this approach we can investigate whether the Phase III mental health laws are truly rights-based—featuring “at the heart”, rights, protections and “a supported decision-making model” (Wooldridge, 2012, Foreword). Or is the ‘rights and service-first’ rationality, at best, an incomplete reflection of state intentions, while at the same time providing normative impetus for regulatory interventions that are intended to address additional, if not alternative, and possibly more pressing governmental priorities?

In the previous sub-section 4.2.2 Strategies, five strategies of the state were inferred from the logic of evidence of the technologies of power in practice and discourse directed to public psychiatrists identified in the Phase III sub-study. These strategies included:

- minimise public dissatisfaction with access or the quality of service
- minimise cost
- minimise the incidence of adverse events
- shift responsibility from the state for adverse events
- provide limited access to acute mental health services to the highest-risk consumers
As depicted in Figure 5, each of these strategies suggest the existence of one or two possibly alternative, but at least additional, state objectives for mental health regulatory policy: to ‘minimise expenditure’ and to ‘minimise public criticism’. In fact, four of the five identified strategies in sub-section 4.2.2 Strategies are simply not explicable in the absence of one or other of these two objectives, with the fifth (the ‘minimise the incidence of adverse events’ strategy) at least consistent with a ‘minimise public criticism’ objective.

These alternative or additional objectives are not public rationalities for mental health policy however, and are, in fact, highly unsuitable to be such. Effectively the political ‘dirty linen’ of the state government of the day, they embody no ostensible truth or moral power to propel the strategies and their vectors of influence in their employ. Rather, as I argue more fully below, these additional or alternative objectives each co-opt normative ‘fuel’ from the three substantive rationalities, to drive the strategies and technologies engaged.

‘Minimise expenditure’
Specifically, achievement of a ‘minimise expenditure’ policy objective would be supported
by a ‘minimise cost’ strategy. But it would also be supported by a ‘limited access for high-risk consumers’ strategy, as reserving a level of service provision for the highest-risk, and yet smallest, band of demand, is innately resource-protective.

By employing such a strategy as ‘limiting service access to high-risk only’ through the technology of mental health law, the ‘minimise expenditure objective’ is able to co-opt the normative value of the stated rationale for that technology—that ‘access to treatment should be facilitated’ whilst ‘protect(ing) consumer rights’. An example was provided in the course of his interview by one senior informant in the Phase III sub-study:

So now my strong view is that you should only admit people to hospital who need to be in hospital. So hospital’s quite a restrictive treatment and involuntary hospitalisation is an extraordinarily restrictive treatment. So that bar for me is very high....

In terms of my responsibility for that, if I’ve got somebody waiting in our hospital in the ED, then I would rather directly ask the question whether that individual could be managed somewhere else...

There’s a little bit of a 20th century, or maybe even a 19th century, idea that you’re [always] treated for mental health issues in an institution. Whereas I believe that the vast majority of people can be effectively treated outside the institution. So that covers my thinking and, not surprisingly, I conform to the legislation where it talks about the least restrictive environment...

The best example would be if there were times where there’s lots of beds available, and if I have any control of that then I will put in another barrier to admission, because [staff psychiatrists] will fill those almost exclusively with admissions who could be treated outside hospital...

This manager enfolds the language of the mental health law principle of ‘the least restrictive form’ of treatment, co-opting the normative, consumer rights fuel it embodies as a management tool to not-so-incidentally manage patient flow in the facility for which he was responsible. Well-aware as he is of the chronic shortfall of supply for mental health services in the community, he denies services—ostensibly to protect their rights—to consumers at the door of his facility, even to those recognised by his own clinical staff as in need of treatment, and even when there are beds available! He would have been encouraged by the broad view of New South Wales Justice Health on the range of environments clinicians should consider as an alternatives to admission:
There are various environments that could be considered from the family home, to independent living, to a group home, to hospital, a hostel or even a park bench. Usually a number of placement options will be available. Using the principles from chapter 5 the clinician must consider the least restrictive placement in which the treatment plan can be safely implemented, work backward from there to the most restrictive option [emphasis added].

NSW Clinical Risk Assessment and Management Guidelines, (Allnutt et al., 2010, p. 54)

The ‘least restrictive’ principle originated in the 1970s as a consumer protection mechanism to constrain the overzealous exercise of medical discretion to provide involuntary treatment (Rose, 1985). It is enshrined in all of the Phase III Acts, as it is in the mental health law in other Western jurisdictions, although its relevance has paled in the current times of seemingly permanent resource scarcity. As Nikolas Rose has written:

It is by no means clear that existence in hospital, in physical comfort and institutional stability, is any more 'restrictive' than the 'liberty' to remain in one's own home unable to reach the shops because of anxiety or depression, visited once weekly by the 'community psychiatric nurse'.

(Rose, 1985, p. 211)

Nonetheless, hospital managers have their jobs to do, and balancing supply and demand, and reducing expenditure where possible, is part of their responsibility. What is interesting for present purposes is the mechanics of power involved—the appropriation of the moral propellant of a mental health consumer rights rationality for the less politically attractive, and yet at least as salient policy objective, of cost minimisation in the sector.

‘Minimise public criticism’
The existence, and indeed achievement of a ‘minimise public criticism’ objective, would be supported by all of the vectors of influence employed in the service of the strategies ‘minimise public dissatisfaction’, and ‘shift responsibility from the state for adverse events,’ and possibly, also, ‘minimise the incidence of adverse events’.

The community holds the state responsible
It appears that the state has identified a problem with the public’s orientation of its responsibility for public safety, and particularly for adverse events that involve people with mental illness. Psychiatrist informants in the Phase III sub-study reflected on what they saw as pressure on the state from the community to prevent bad things happening to and by people with mental illness:
I think there is certainly that—that it must be hell for people with loved ones of people who have killed themselves and what are you left with? You can be angry at the person who’s killed themselves. But that’s almost obscene, you can’t do that. So you can be angry at yourself, but that’s going to overwhelm you and destroy you. Or you can be angry at an organisation. That’s actually easier.

[Female, 40-54]

Yes, so I shoot someone on a train, and it’s just their parent’s fault, whereas if I shoot someone on a train and I have schizophrenia, it’s the system’s fault. And so, there needs to be a more sophisticated...we need to give up on putting [psychiatrists] in the city square and throwing bad tomatoes at them after bad things happen.

[Male, 40-54]

Suicide is potentially seen by society as reversible. It shouldn’t happen.

[Male, 55+]

If somebody’s cancer gets the better of them, it’s kind of, one is almost sympathetic towards the physicians and the teams involved. That they have tried something, tried very hard, and yet they lost that person. Whereas with suicide and mental health risk it’s: ‘you should have done your job better’. There is that sort of sense that—the sense is that somehow you should have prevented that... You just didn’t keep them safe enough [emphasis original].

[Female, 40-54]

Informants reflected that violent acts committed by people with mental illness seem to carry more horror in the public mind than those committed by the mentally well and, further, that such events are seen as avoidable if the state system is doing its job properly. This data, along with evidence of nuanced strategy on the part of the state to both minimise such adverse events and its own responsibility for them, suggests considerable concern on the part of the state about the electorate’s anger and fear in relation to adverse events. As argued below, this thesis suggests that the ‘minimise public criticism’ objective co-opts considerable normative amplitude from the rationalities advanced within mental health law.

Co-opting the ‘facilitating access’ rationality

To address public concern about the adequacy of access to mental health services, access is made an object of the law which demonstrably provides machinery for a certain model of public mental health service provision. There is no indication in the objects, however, of the very limited (by risk) nature of the provision, and of course, no indication of its even more limited application in practice. Furthermore, the capacity that fine tweaks to mental
health legislation have to alter, at least in theory, the catchment of the legislation in relation to the ‘facilitate access’ objective is routinely touted by parliamentarians, although without any consistency, and without consideration of, or data about the use and effect of the law in implementation (Hansard, 2012; Rees, 2007; Winterton, 2007).

Informant reports in the Phase III sub-study support the thesis that the state is concerned to ensure that citizens continue to believe they are receiving a satisfactory quality of mental health servicing, even if they are not:

There was a very high-functioning and intelligent female researcher who came out to do a conference not so long ago and she was very high-up in medical politics. She said: ‘I went to the health minister in the UK and said we’re not providing evidence-based treatments. There’s x y and z that have an enormously great capacity to treat and care for people, but you’re providing these ones that are behind the times and cheaper’. It just fell on deaf ears and she tried to make another meeting... Ultimately she went to the media, not in a combative, aggressive way but just to say the public need to know that the NHS isn’t providing the optimal, evidence-based treatments. ‘[There are] some very good treatments that aren’t a lot more expensive and you’re not getting them’. She got a phone call saying: ‘can you come in and see us now’? Things happen because [of] the capacity to lose favour with voters and the public.

[Male, 40-54]

Well I think it’s the kind of Australian-style myth of universal health care. Everyone loves Medicare. Everyone loves the idea of universal health care. It’s like a big mother giving the country a hug when it’s sick. Then we contrast it with countries that don’t have universal health care. Part of the myth of universal health care is that it’s health care for everyone, and it’s evenly distributed, and it’s what you need...and [the state doesn’t] want to break down that myth...

[Male, 40-54]

These results are supported by polls about the significant level of concern about mental health issues in the community (Ipsos MORI, 2010). They are consistent also with a long-held valorisation of the quality of Australia’s public health services:

Australia has a long and proud history of universal access to health care.

(Australian Healthcare and Hospitals Association, 2013, p. 3)

As reported at sub-section 4.2.1.4, the Phase III sub-study identified a ‘support and protect the service’ discourse as one of the technologies-of-the-self leveraged against public psychiatrists. The origins of the pressure on psychiatrists to contribute to the maintenance of ‘the universal health care myth’, notwithstanding that their daily reality almost invariably
involves restricting access in the form of resisting admissions and discharging early, rest in a furtive anti-criticism agenda fed by the powerfully positive ‘facilitating access’ rationality.

**Co-opting the ‘protect consumer rights’ rationality**

The ‘minimise public criticism’ objective is also supported by the ‘protect consumer rights’ rationality as set out in mental health law and elsewhere. This is consistent with the positive self-image Australia possesses in relation to human rights matters. Australians still consider that their country’s commitment to human rights is part of its success as a stable nation (von Doussa, 2013), part of its ‘good-guy’, international self-image (AAP, 2014). International human rights treaties are increasingly and frequently applied as authorities for fundamental principles in Australian courts (Kirby, 1993).

The state touts the human rights credentials of its mental health policy in prolix statements both within and outside mental health law. Within the law, the removal of a patient’s freedom to move and make treatment decisions—because the risk of harm ostensibly posed—is justified by replacing medical norms with legal norms to provide firm, objective, appealable grounds for this outstandingly invasive intervention (Winterton, 2007). The genuineness of the elevation of the risk-of-harm model, in rights terms, has been questioned however (Freckelton, 2009, 2010). Rose, also, has identified the historic co-opting of the rights discourse within mental health policy for less apparent objectives:

> The social reality of rights-based strategies is not to transform the relations of dominance between professionals and those subject to them, but to effect a redistribution of status, competence and resources amongst the many sectors involved in the professionalisation of unhappiness… For the psychiatric reforms urged in the name of the ‘least restrictive alternative’ did not flow from the discovery of a right. On the contrary, the 'right' was invented as the ground for the desired outcome. The language of rights disguises a social judgment and a political strategy [emphasis added]

*(Rose, 1985, p. 212)*

In this passage, Rose confirms conclusions reached in this thesis. First, as I have done in this Phase III sub-study, he distinguishes the separate impetus of “the right” as a political rationality, “rights-based strategies” (governmental strategies and technologies), and “desired outcome[s]” (‘additional’ state objectives in this thesis). He identifies disjunction between the rights rationality and “desired outcome[s]”, whilst at the same time pointing to the harnessing of “the language of rights” for alternative purposes. Under Rose’ analysis, however, rights language is annexed to a state objective to reduce the power, resources and autonomy of psychiatrists in the mental health field. In this thesis, I argue that the
normative energy of the rights rationality is affixed to a more pressing imperative—to
minimise electoral concern by maintaining the myth of universal mental health care.

Appropriating the ‘protect the community’ rationality

Last, I suggest that an objective to minimise electoral criticism is clearly supported by the
‘protect the community’ rationality in mental health law—as timidly expressed as it is (present
in only 4 of the 42 Phase III Act ‘objects’ statements). For despite the concern about
adverse events in the community as reported in the Phase III sub-study, and elsewhere, the
rationality of protection appears to have less positive normative power than the other two.
An explanation may lie in the logical conflict implicit in the ‘protect consumer’ and ‘protect
society’ rationalities. Nonetheless, as reported in sub-section 4.2.3 Rationalities of mental
health law, the ‘protect the community’ rationality is supported by the vast detail, complexity,
and the sheer bulk of legal discourse addressing risk-based involuntary treatment and
detention within the body of the Phase III laws. Considered with the evidence of concern
about adverse events in the community arising from the Phase III sub-study, the deep and
broad scope of this technology supports the inference of a ‘minimise electoral criticism’
objective.

Conclusion

Phase III analysis has produced results that are consistent with the conclusion that the
regulatory strategies of the state, and particularly the risk-of-harm model of mental health
law, are more aligned with an agenda to minimise expenditure and to reduce criticism in the
electorate than the stated rationalities of facilitating access and protecting consumer rights.
This is not to allege state disinterest in service provision or consumer rights protection but
rather to suggest that electoral and budgetary objectives ‘trump’, and also inevitably
compromise the achievement of, the ostensible policy drivers.

This finding is consistent with Rose's (1985) analysis of invented grounds and
disguised, desired outcomes in mental health regulatory policy. Derived from evidence
from the Phase III sub-study of the “social reality” (Rose, 1985, p. 212) of mental health law
in action—“where the rubber hits the road” (Fairbanks II, 2008, p. 36)—these results
demonstrate disjuncture between the stated rationalities and objectives of the state in mental
health policy, the so-called ‘inconvenient facts’ (Dean, 2009; Gordon, 1991). This is an
instantiation of pure governmentality-in-action in the assemblage of state-public psychiatrist
power relations.
4.2.5 ACTIONS EXTERNALLY BY PSYCHIATRISTS

We cross the interstice now between the actors in the A1 assemblage, to consider the response of the public psychiatrists to the vectors of influence projected towards them by the state as described in the preceding sections.

This thesis separately addresses actions-in-response that are ‘external’ to the subject, (in terms of the object of the response), and actions-on-the-self, which resonate internally to the subject.

As McKee (2009) identified, subjects in power relations are no mere empty vessels waiting to be filled with the influencer’s agenda. Rather, as described in sub-section 2.6.3, they may choose, in their freedom, to respond in accordance with additional, alternative or lower rationalities. This variation between programming and effect is one of the principal insights available from empirical governmentality research (Dean, 2009; McKee, 2009). The Phase III sub-study has been no exception, identifying a broad and interesting range of responses by public psychiatrists to the regulatory influences exerted by the state.

Additionally, the study has revealed data that support a perspective of ‘governmental flow’, the second of the specific analytic focii identified in the Phase III sub-study methodology. In this process, the action-in-response does not only not conform with the intentions of the influencer, but also takes form as an outgoing vector of influence, directed either back at the original influencer, or externally to another stakeholder.

The range of subjects’ external responses to an expression of regulatory influence has been characterised by Braithwaite et al (2007) who classified the motivational postures of nursing home managers in relation to regulatory interventions exercised upon them, as described previously in sub-section 2.6.1 Elements of governmentality assemblage. In reporting results of this Phase III sub-study however, the several complex phenomena suggested will be grouped into only two theoretical categories: compliance (incorporating Braithwaite’s ‘commitment’ and ‘capitulation’) and resistance (which covers Braithwaite’s ‘resistance’, ‘disengagement’ and ‘game-playing’ classifications but deals additionally, also, with the notion of subversion).

The Phase III subjects’ external responses that comply with the intentions of the influencer are reported in the following sub-sections 4.2.5.1 Compliance: Gate-keeping and 4.2.5.2 Compliance: Provision of risk-focussed usual care.

Resistant external responses are described in sub-sections 4.2.5.3 Resistance: Blame
avoidance to 4.2.5.5 Other resistant practices. Their effect as new vectors of influence in assemblages other than A1a will be described in section 4.3 Governmental flow in assemblages supra.

4.2.5.1 COMPLIANCE: GATE-KEEPING
The interpretation of compliance is a complex task but one befitting the sensitive, critical lens of the governmentality analytic. All of the informant psychiatrists continue to be engaged by the state. It is clear then that all of them must comply, to a degree considered at least as satisfactory, with influences exerted upon them by their employer, the state. Yet resistant practices were also identified.

So what practice does their compliance comprise? The study identified two categories of compliant practice in response to the vectors of influence exercised by the state through the technologies identified in the previous sub-sections. As depicted in Figure 6, these included gate-keeping practices, and care provision with a risk focus.

These compliant practices were generated in response to the vectors of influence identified previously: ‘de-professionalisation’, the ‘prioritise risk’ discourse, the ‘manage scarce resources’ discourse and the ‘support and protect the service’ discourse. The technologies transmitting these forms of influence to psychiatrists were described in sub-section 4.2.1 Technologies of power: The law infra and in Appendix C to this thesis.

The balance of this sub-section discusses results in relation to the compliant practice of gate-keeping.
What is gate-keeping?
Phase III sub-study results generated responses signifying a group of practices identified as ‘gate-keeping’. The Merriam-Webster Dictionary defines ‘gate’ as a means of entrance or exit (“Gate”, 2015), and provides a medical definition of ‘gate-keeper’ as a health-care professional (such as a primary care physician) who regulates access, especially to hospitals and specialists (“Gate-keeper”, 2015). For the purposes of the Phase III sub-study, the action of gate-keeping is defined as formal and informal practices undertaken by Phase III informant public psychiatrists to regulate ingress to and egress from public mental health services in response to influences exerted by the state.

There were many examples of gate-keeping practices reported by informants. They were grouped in analysis into nine types, ordered below in accordance with the number of informants who mentioned such practices:

- By varying risk assessment practice with bed availability (18 informants reporting)
- By discouraging ‘bed-blockers’ and ‘non-deserving’ patients (10)
• By flexible interpretation of ‘risk’ (7)
• By manipulation of the definition of mental illness (4)
• By ‘hand-balling’ (2)
• By maintaining a high threshold for appropriateness of hospital treatment (2)
• By engaging mandatory time limits on hospital stays (1)
• By returning responsibility to patients (1)

Because of the small sample-size and semi-structured interview method, caution should be exercised in attributing significance to the relativity of reported practices, with the possible exception of ‘varying risk practice with bed availability’, where the result is substantial. Each of the identified practices is described below.

**Varying risk assessment practice with bed availability**

Fully two-thirds of informants explicitly confirmed that the practice of risk assessment by public psychiatrists varies as bed availability varies. Several informants provided specific instances. At interview, some informants, mostly younger practitioners, displayed discomfort with the topic and, whilst agreeing that the practices took place, quickly concluded the line of discussion. Some excerpts from the more elaborate responses follow:

...people being brought in completely unwell and because of bed pressure being discharged several days later, only slightly less unwell while meeting the criteria. I see that a lot.

[Male, 25-39]

It may be that people [the psychiatrists on duty] have made the decision about what they’re going to do and then made sure the risk assessment falls in with what they were intending to do rather than what they should be doing. If you were to look at the risk alone ...you may be forced to do something that you’ve already decided you’re not going to do. So they then might change the assessment accordingly.

[Male, 40-54]

[Risk] has also become the dominant means of resisting admission. If you can argue that the risk is small or low or not likely to be changed by hospitalisation... If you can make that judgment it makes it easier to resist an admission.

[Male, 55+]

...there is some sort of mismatch. For example, this would put us in an awkward situation, my clinical engagement [with the patient] is saying ‘this patient needs to stay for two more weeks’ but the patient is not voicing any risk. I think, based
on my experience—I know, that in the past they have ‘done it’—that they need another week. But the form says there is no risk, so I have to discharge this patient. There is dishonesty between what the form says and what the clinicians experience is.

Discouraging ‘bed-blockers’ and ‘non-deserving’ patients
Informant psychiatrists described action by themselves and their colleagues to inhibit access to acute psychiatric services for patients suffering from age-related mental illness, homelessness and substance-abuse. They generally acknowledged these patients’ need for a form of treatment but were concerned that the need was too long-term, or otherwise not an efficacious use of scarce, acute mental health resources:

We spend lots of time on people who don’t want to be here. They’ve got a drug problem, and they don’t want to do anything about their drug problem. So they’re in an $800-a-day bed, learning nothing. They don’t want to learn anything. Some are dangerous and some are just nuisances. They’re not doing anything of use, they’re just a pain in the neck to society. When they get directed to me, I say no. But then I hear they’re coming over anyway...

Creative interpretation of ‘risk-of-harm’ provisions in the law
A number of informants described the invocation of a legal notion of ‘risk-of-harm’ to assist in argument to resist an admission. This sometimes involves the use of language not intended nor expressed in the law but treated as if it is. The phraseology cited included: ‘imminent risk-of-harm’, ‘guarantee of safety’ and ‘likely to create the greatest damage in the immediate future’:

...so in an ideal world, people who can’t be managed, who have a mental illness, who can be treated, are admitted. But that’s not actually the way the thing functions at the moment. What’s happened over the last 10 years is that there’s been an informal rewriting of the Mental Health Act that says...a patient can only be admitted to a psychiatric institution if, at the time of assessment, they represent an imminent risk-of-harm to themselves or to others [emphasis added].
My heart sinks when, for example, a registrar says ‘oh well, they can’t guarantee their safety’. I think, well, you can’t guarantee anybody’s safety...asking a person “can you guarantee your safety?”’, and then saying “well, we’re going to admit them because they can’t guarantee their safety” [emphasis original].

One example I will give you is about trying to get a person seen by the older person’s mental health service in [jurisdiction name]. It’s virtually impossible. Not only do they have to have a mental illness and be of the right age, they also have to have something nebulous called ‘issues of aging’ or ‘cognitive deficit’. I don’t know what these nebulous things are! So this is what I mean. People can interpret guidelines in whatever way they need to interpret them.

I don’t think anyone goes out with that intention and I don’t think, I actually think the Mental Health Act is a very useful Act. I think the problem is, in the face of scarce resources, that interpretation then becomes an issue. It then gets used in a way that it was never designed for.

By variations in practice engaging the diagnosis of mental illness and its qualifying importance under the law

Informants also reported the use of the definition of mental illness, although not necessarily the precise definition under the relevant Act, to resist admissions because of service limitations, perceived non-treatability or the perceived troublesome or complex nature of the patient’s difficulties:

Informant: I mean the other way they use it, which is kind of much more malevolent...this is the notion of the criteria that you must have a mental illness...‘on the list’, it’s either DSM or ICD. Then it’s sort of: the Axis 1 list, which is the kind of disorders list as opposed to the personality list. So someone who has a borderline personality disorder, who’s in crisis, and cuts up and presents for containment....or is in a medical ward and they have cut themselves. Our ward says: “We can take them”...But then a manager comes along and says we can’t... We say: “Why?” [And they say:] “Because they don’t have a mental illness...”

Look. It’s a very practical way of...doing something...What you’d actually want to say is—“look, there is no value in admitting this person to the ward. It doesn’t reduce their chance of doing things. And they create chaos”.... But you can’t, you don’t, say that, you say: “well they don’t have a mental illness”. Now when you say that to the patient’s parents and to the staff, they say: “…that seems ridiculous—this person’s cut
themselves up with a razor blade and you’re telling me they don’t have a mental illness?”

Interviewer: Malevolence. It’s a strong word. Where is the hurt felt in the use of the Act that way?

Informant: By the people asking for help and their families. Rather than there being an explanation, of “look, it doesn’t really help” or “we don’t have the resources” or “we’re never going to admit your daughter to hospital again, she creates such pandemonium we had to discharge her”, instead we say: “we can’t admit her because she doesn’t have a mental illness”.

[Male, 40-54]

But the other thing that gets used is the control of the finding of mental illness. The judgment as to whether there’s a mental illness or not can be influenced by the availability of the bed.

[Male, 55+]

Restricting access by engaging the definition of mental illness in the relevant Act is also used in a way that informant psychiatrists considered both benefited the patient and ‘safeguarded the turf’:

Say for example somebody has a delirium following urinary tract infection. They’ve clearly got a delirium but they’re showing no psychiatric symptoms. Hallucinations, delusions as part of that... As soon as somebody starts hallucinations, the calls rise for this person to be transferred to psychiatry, which I think is sometimes both dangerous and medically unprofessional and unnecessary and stigmatising. So in one respect, it’s useful to be able to quote the Act and say: “look this patient doesn’t meet reasonable criteria within the Mental Health Act to be admitted involuntarily”.

We get asked to admit a 40-year-old patient with no psych complaints at all to an aged psychiatry ward ‘to help with patient flow’. Which means this young woman gets stuck in a ward full of behaviourally-disturbed patients. She gets a record against her name on the ...database so if somebody looks they’ll see she’s had a psychiatric admission. She’s not been involved in the decision. [We ask:] “Is she agreeing to come?” [They say:] “No, she doesn’t want to”. [We say:] “Are you suggesting we admit her as an involuntary patient?” So we can use the words [in the Act] to safeguard our turf.

[Male, 40-54]

‘Hand-ball ing’

A small number of informant psychiatrists reported gate-keeping by early discharge of resource-intensive or otherwise ‘difficult’ patients, with an accompanying adjustment to the risk assessment. This practice was referred to as ‘handballing’ or ‘turfing’.
We had a patient not too long ago from one of the large jurisdictions who came in floridly psychotic, very unwell and with lots of risk factors. He undoubtedly needed care... He had been admitted and discharged two or three weeks previously from this other hospital. We got hold of the discharge information, which was quite extensive, and it actually explicitly stated ‘because looking after this man once he’s discharged from hospital is impossible with or without [an involuntary order] we’ve not bothered’. Effectively he hadn’t been seen [since discharge]. Had been known to be unwell for many years. Came in [to the other hospital] for a week on a voluntary basis. Then he was discharged knowing that would be the last they saw of him. I think there’s very much a mentality in Australia that certain patients get put in the too-difficult basket. They’re simply moved on.

In the...community team where we work, we have the city centre itself as part of our catchment area, and often we are the recipient of ‘hand-balls’ from other places where they have been allowed to leave hospitals prematurely. Knowing that [the patient is] not likely to abide by the plan that’s been organised. At the same time, not caring if [the patient] falls out of their catchment area into ours. So we have that situation where they’re being, I suppose, a bit, I could say, negligent. But certainly less committed than they otherwise should be I suppose.

We call that a ‘turf’. You just turf it elsewhere.

By maintaining a high threshold for appropriateness of hospital treatment
Two informants reported using the mental health act criterion ‘least restrictive treatment available’ as the principal guideline for deciding who they will admit to treatment at their acute mental health facilities.

I believe that the vast majority of people can be effectively treated outside the institution, so that covers my thinking, and not surprisingly I conform to the legislation where it talks about the ‘least restrictive environment’.

By engaging mandatory time limits on hospital stays
The imposition by management of time-limits on length of patients stays in hospital was reported in one jurisdiction despite that clinicians felt that the period allowed was too short to achieve treatment aims:

I have had pressure, personally, from senior managers of clinical services, [from] various places, to discharge patients. To the extent that they even dictate these dates—two weeks is the admission time for any patients returning to the hospital
and that is made clear from the start... But some of the patients are very complex and you have to get information from GPs, family meetings and even for the medications to kick in, it takes three to four weeks in most cases.

By returning responsibility to patients

Surprisingly, only a small number of clinicians referred to the responsibility of the patient in any context in the course of the study, the operative assumption appearing to be that a public mental health consumer’s self-responsibility is intrinsically displaced, to become the responsibility of another actor (the state or the psychiatrist), or at least is temporarily subsumed by their mental illness. But one informant clinician co-opted the notion of self-responsibility as a strategic aid to support the decision to discharge:

*Convincing people to go home because it’s in their best interests, is what I use. I certainly would—if there is no bed available, I would certainly tell them that. But I would never [say just] that as the only reason that they should go home...I think, more importantly, you convince them in terms of their best interests, the family’s best interests. The risks of staying here or not going to school or not going back to work... Really, to make them see hospital as a toxic necessity.*

Conclusion

Phase III sub-study found that many employed psychiatric clinicians respond to vectors of influence by the state, in particular the expressions of influence requiring psychiatrists to take responsibility for compulsory treatment and detention, and to protect scarce mental health resources, by engaging in gate-keeping practices. The many and varied gate-keeping practices in use Phase III jurisdictions are a compliant response by psychiatrists to those expressions of influence, in that their action is consonant with the behaviour strategically sought from them by the influencer, the state.

Practices that involve use of mental health law provisions for these purposes included: variation in risk assessment with changes in bed availability; creative interpretation of ‘risk-of-harm’ legal provisions; use of the definition of mental illness to exclude patients; and maintenance of a high threshold for the appropriateness of hospital treatment.
4.2.5.2 COMPLIANCE: PROVISION OF RISK-FOCUSED USUAL CARE

A range of informant data featured the type of care and treatment provided by public psychiatrists. Many informants elicited concern that practice and discourse within their working environments compelled their compliance in the form of their provision of risk-focused care, which they distinguished from the needs-based care central to their training and ethics as medical practitioners.

What is risk-focused care?

The essence of risk-focused care practice, as identified in the Phase III sub-study and described in more detail below, included: prioritising high-risk patients; provision of treatment focussed on risk management, and defensive documentation protocols.

Prioritising high-risk patients

Informants reported that the combination of the two dominant discourses ‘prioritise risk’ and ‘manage scarce resources’ significantly influenced their professional practice. They felt pressure to give precedence to patients assessed to be at the highest risk of causing the most harm, whilst knowing that available resources would not then stretch to helping others who were more clinically needy, who were suffering more, or who could be treated more effectively but assessed to be at less risk-of-harm:

The reason risk management has become the latest catch phrase in psychiatry for the past 10 years is because there are so few beds for people who absolutely and positively need them. Risk has become the defining criteria to determine access to a scarce resource.

Risk assessment has been put on a pedestal as the arbiter of most of our decision-making and that’s simply because we only have the resources to admit the patients with the highest risk. It’s a way of taking the top off—there’s plenty of extremely unwell people out there. There’s a much smaller number who are extremely high acute risk. Those are the ones who get the resources in an inpatient setting. Paradoxically, they invariably are the sickest people in the community who we have got the least chance of actually doing anything for...but that’s the way the system works.

[Male, 55+]

So we have these social problems who present and they often get a bed. Because we don’t know what else to do with them, and we’re scared that if we send them away they’ll suicide. And also they tell us that they are depressed.
The world has completely been made useless by Beyond Blue and all sorts of other medicalisation processes that have—that has created the situation that anyone who says they are depressed [ends ups being diagnosed] with a major depressive episode [or] disorder. They have just listened to too much Beyond Blue.

[Male, 55+]

Changing the nature of psychiatric care

More than just about warp in the prioritising of patients however, informant clinicians evinced serious concern with the corruption of their capacity to provide needed care and treatment by an ‘industrial’ imperative to identify and clinically manage risk. The study elicited numerous and various informant descriptions of the substitution of risk assessment and management processes for appropriate, needs-based psychiatric medical care:

... the concern is that there are people and there are systems that become focussed on risk assessment, for the purpose of risk assessment, and become sort of industrialised around risk assessment.

[Male, 55+]

...that [psychiatrists say they have] documented a risk assessment, therefore they did everything they should have been able to do. But “I did the risk assessment, that’s all I could do” is against even the pseudo-logic of the risk assessment!

[Male, 40-54]

I think it’s happening more and more, people are...they complete an assessment and then they think they’ve ‘done it’.

[Male, 55+]

That the organisation itself is set up for, the hospital...it does tend to be set up for security and risk minimisation, rather than for treatment and best outcomes. Generally those things take precedence over traditional clinician's values.

[Male, 55+]

The law obviates the need for care.

[Male, 55+]

Defensive documentation

A preponderance of form-filling was seen as a major practical component of risk-focussed usual care. Informants identified that the requirement to comply with risk-focussed documentary protocols, transmitted via the technology of employment, represented a type of defensive psychiatry designed to protect not the individual clinician, but the state service.
Interviewer: Do you feel a pressure that the assessments you make are correct?

Informant: My assessment is that as long as you’ve asked The Question, nobody cares.

Interviewer: What question?

Informant: “Are you going to hurt yourself; are you going to kill?”

[Female, 40-55]

The technical medical director at the unit I was working in—it wasn’t me—would say: “Well, this has got to be filled in. And this has to be filled in”. And then the registrar: “This has to be filled in”. And the nursing staff: “This has to be filled in. Which boxes do we tick here?” So the risk management was kept up. Every week, every patient.

[Male, 55+]

So the way the history is taken—it has a very strong effect on the way the case is constructed. The way the history is taken, it’s often taken with the needs of the organisation in mind.

[Male, 55+]

Well I mean really—why are we filling out these forms!? They’re really medico-legal defence forms! They’re a demonstration ipso facto that “we were thinking about this at the time”. And that that’s all we were doing. Whereas what we’re actually doing is much, a much more complex thing...

[Male, 39-55+]

The importance of the documentation strategically, for the state, is supported by policy guidelines published by one service:

If the hazard does occur, the risk assessment and management plan will provide an understandable and transparent explanation of the decisions taken and provide the clinician and the Mental Health Service a defensible position.

NSW Clinical Risk Assessment and Management (Allnutt et al., 2010, p. 15)

But ‘risk is part of care’...

In contrast, there were a number of clinicians who saw no particular conflict between risk-focussed care and appropriate treatment. They felt that ‘risk is part of care’. One younger registrar [Male, 25-40] said he’d found it difficult to imagine anything but risk-focussed care; that he has “grown up in it”. A senior clinician described that she felt comfortable with a risk-focussed care regime, saying she found it hard “to think outside that box”. Another
younger clinician spoke about “doing both”:

Risk assessment...has strong legal overtones [but] there’s a different sort of relationship you have with a particular patient. I think you can have all of the, sort of, good things [in a therapeutic relationship]...and that incorporates a decision about whether the level of risk justifies [an order] or the continuation of [an order] without it necessarily being a particularly damaging thing...

Sub-section 4.4.4 provides further discussion about the relationship between risk-focussed care and alternative forms of appropriate, needs-based psychiatric treatment.

Conclusion
The Phase III sub-study found employed psychiatric clinicians informants felt pressure—particularly from influence transmitted by mental health law and the technology of their employment—to practise with a primary focus on risk management at the expense of other clinical and ethical demands.

Public psychiatrists’ provision of risk-focussed care, in Phase III jurisdictions, can be configured, then, as a compliant ‘action external’ to expressions of influence by the state.

Mental health law is implicated in the carriage of relevant vectors of influence (principally, by the responsibility for compulsory treatment and detention; ‘risk takes priority’ discourse; and the ‘support and protect the service’ discourse) and in the psychiatrists’ actions-in-response (prioritising high-risk patients; risk-focussed treatment; and defensive documentation).

4.2.5.3 RESISTANCE: BLAME AVOIDANCE
In contrast to the compliant practices so far described, the Phase III sub-study also identified a range of practices by psychiatrists in response to vectors of influence exerted by the state, that contradict the behaviour promoted by those vectors. These actions-in-response by psychiatrists were identified as resistant. Their governmental genealogy is summarised in Figure 7.
Figure 7  
*Assemblage A1a: The genealogy of resistant practices*

**How does blame avoidance arise?**

The Phase III sub-study found that all but two of the 28 informants considered that the professional stress arising from possible or actual blame for adverse events was too high.

Informants reported pressure to bear significant risk of blame for adverse events arising from their decision-making, and most particularly, from early discharge.

**Fear of blame stimulates anxiety and despair**

Informants frequently spoke in terms of managing anxiety arising from their clinical decision-making:
Informant: I think there is that, there is the sense, people feel that they will be blamed or held to account, rather than a service.

Interviewer: Does that leave them to make more conservative risk assessments, that pressure?

Informant: I think it does. Reflecting back on the experience, I think people became very anxious about taking risks [emphasis added].

[Female, 40-54]

Well [the managing clinicians] used to be clinicians but they’re not seeing patients anymore. They carry this anxiety. So what do they do to kind of assuage this anxiety? They set up processes. Like risk assessments. So all that anxiety gets channelled through processes which are defensive, which essentially, support them when things go wrong. Because that’s their fundamental anxiety, what happens if something goes wrong...It doesn’t actually—it’s not a method of treating people—it’s a method of managing the anxiety which is transferred into people who aren’t looking after patients [emphasis added].

[Male, 40-54]

But on the whole [my colleagues], they’re pretty good and this is the sort of work they do. They can contain—you can’t work on this sort of team if you can’t contain your anxiety to some extent [emphasis added].

[Female, 40-55]

So that’s part of what we have to do as a psychiatrist is to hold anxiety and still make decisions based on clinical, ethical, personal factors [emphasis added].

[Male, 40-54]

I guess from observing, I think people [other clinicians] run into problems sometimes, because they don’t actually think through why they want the admission. When it’s just a matter of relieving their own anxiety [emphasis added].

[Female, 40-54]

I think the problem with risk assessment is actually that adverse events in psychiatry are low in number, so how’re you gonna pick? For example, yesterday I sort of fell over someone who has a chronic psychotic illness. There is some history of aggression towards his mother, kind of contextual as well. I see him, he agrees to come and see me, but I can’t really get anything... Does he pose a risk to his mother? If I could not tolerate any anxiety about that, I would possibly use the Mental Health Act to do something [emphasis added].

[Male, 40-54]

Interviewer: Does that leave them to make more conservative risk assessments, that pressure?
Informant: I think it does. Reflecting back on the experience, I think people became very anxious about taking risks [emphasis added].

[Female, 40-54]

Several informants referred to great differences between practitioners in terms of the amount of risk of blame they are prepared to bear.

Interviewer: How do you see that pressure playing out amongst your colleagues? You mentioned that younger people have more urge towards the conservative side.

Informant: Not necessarily young. There are some older who do not want to tolerate any kind of risk, they are so aware of political or judicial issues that they just accept no risk. Then there are others who accept too much risk. I don’t know that there is a happy medium and with these sorts of pressures, it pulls a clinician in enormous directions, to try and work out what to do.

[Female, 40-54]

Managing anxiety by managing the possibility of blame

Both of the two clinicians who did not consider that the pressure in relation to blame for adverse events was significant, nevertheless engaged in creative forms of defensive practice to ‘manage blame’ and forestall the development of anxiety:

In terms of sort of adverse events, you have to take a long enough snapshot of it, and most times the people that get bothered by those things—they haven’t taken a long enough snapshot. But...you also have to be confident about your own capacity and process for instant review, and personally and systemically on being able to put up [a defence] if there’s a problem.

[Male, 40-54]

Interviewer: Do you find yourself erring on the side of caution?

Informant: Not hugely. If I have doubts—I might even go to the tribunal and say explicitly: “I’m not sure”. I have done that a few times in [other jurisdiction] as well. My view is that if, subsequently, something does go wrong—somebody is not on [an order] or something untoward does happen—then I guess I can refer back to my doubts.

[Male, 25-39]

Defensive practice (for the benefit of the psychiatrist)

Defensive practice is decision-making about patient treatment with a view, primarily, to avoiding exposure to criticism, blame, or other accountability procedures such as medico-legal litigation (Mossman, 2009).
In sub-section 4.2.5.2 Compliance: Provision of risk-focussed usual care above, it was noted that compliance with the risk focus involves defensive practice, particularly in relation to documentation, which is oriented to protecting the state medico-legally.

But the study identified a second narrative stream about defensive practice. These were stories of resistance to the state’s attempts to influence psychiatrists to personally and professionally bear blame for adverse events, exercised through the state’s accountability technologies and through mental health law. The resistant responses to these vectors involved practical effort by clinicians to avoid or shift away from blame.

The Phase III sub-study found that the pre-eminence of the risk focus, as formalised by mental health law, affected the type of patients treated by informant doctors, the nature of conditions treated, the type of treatment provided and the time devoted to non-risk-based treatment modes. These delimitations on practice caused particular discomfort amongst informants in relation to possible future scrutiny of their actions. Fear of blame tilted the tenor of everyday practice towards pre-occupation with medico-legal defence.

**Blame avoidance = positive risk assessment**

‘Blame-retardant’ defensive practice by psychiatrists was found to feature, at its heart, conservative risk assessment. Though subject still to state influences promoting gate-keeping practices (which promote the incidence of false, negative risk assessments) most informants conceded directly that they were much more likely to make false, positive risk assessments, in response to their fear about being held responsible for adverse events.

**Defensive practice in the literature**

Studies support these results showing an extraordinarily high prevalence of defensive practice amongst psychiatrists. Passmore and Leung, for example, reported that almost three-quarters of UK psychiatrists had practiced defensively in the 30 days prior to their survey response (Passmore & Leung, 2002). The Royal College of Psychiatrists in the UK reported that fully 60 per cent of clinicians believe, in fact, that medico-legal defence is the prime purpose of the risk-based protocols (Kennedy, 2008). Richard Mullen analysed 86 surveys returned by New Zealand mental health clinicians and concluded that defensive practices were commonplace, with some clinical practices performed for defensive reasons more often than not (Mullen, Admiraal, & Trevena, 2008). In contrast, his namesake, Paul Mullen, has claimed there is no blaming culture in Australia, little media interest, and suggested that psychiatrists in Australia could sustain more, rather than less, responsibility for adverse psychiatric outcomes (Kennedy, 2008, p. 22).
The types of risk-based defensive practice identified in the literature, also, are homogenous with the types of risk-based defensive practices reported in the Phase III sub-study. They include: excessive questioning of patients about their safety; risk-based admissions; delayed discharge; over-use of formal observation; higher levels of restraint, restriction, medication, and the use of mental health legislation (Mullen et al., 2008). They are analogous, also, to practices found by Keyzer and McSherry (2013) to be associated with the risk assessment of ‘dangerous’ sex offenders:

‘Risk management’, remarked one Queensland lawyer, has become a matter of ‘how do you protect the system from criticism for being negligent in their duties to the community’. Another Queensland lawyer noted that there is ‘an underlying fear at all levels of the process that “I don’t want my signature on the one that gets released and…does something very nasty”.

(Keyzer & McSherry, 2013, p. 301).

Non-engagement

The phenomenon of ‘hand-balling’ or ‘turfing’ of difficult or complex patients to other service areas was reported in the earlier sub-section 4.2.5 Actions externally by psychiatrists as a compliant response to the pressure to manage scarce resources. There were indications from the Phase III sub-study, however, that such practices might be part of a more general phenomenon where clinicians sometimes avoid engagement with a patient so as to avoid responsibility for possible negative outcomes:

Interviewer: What does [the experience of coronial inquiry] teach [young psychiatrists]?

Informant: Well it teaches them that everything they should do should be either directed towards stopping bad things happening OR if something bad is happening to make sure that it is someone else’s responsibility [emphasis original].

[Male, 40-54]

Interviewer: Wouldn’t it be safer for you to have them on [an involuntary order]?

Informant: No, because then I’m responsible for them.

[Female 40-54]
4.2.5.4 RESISTANCE: CASE-MAKING

What is case-making?

The Phase III sub-study identified a set of practices consistent with the notion of ‘case building’ as identified by Alisa Lincoln, in response to state influence:

[Staff meetings were dominated by discussions of how to get people into the hospital and physicians were frustrated by their inability to provide needed services. ‘Generally, we no longer worry about who we falsely imprison, we worry more about people getting in or getting kicked out once they get in’ (Dr. M). Physicians referred to surmounting the obstacles to admission as ‘case-building’. Building a case involved gathering information from as many sources as possible to show that a person had met the commitment criteria. (Lincoln, 2006, p. 64)

The practices identified in the Phase III sub-study similar to those described by Lincoln will be described in this thesis as ‘case-making’. Like the compliant practice ‘gate-keeping’, case-making emerges in response to the risk and scarce resource discourses. Precisely opposite in effect to the gate-keeping response, however, case-making practice is employed by clinicians to get particular people in. The Phase III sub-study found that psychiatrists routinely engage involuntary treatment provisions in mental health law as a strategy to ensure access, or continuation of access, to treatment for patients who might not otherwise receive it—that is, if the thrust of the regulatory risk and resource discourses prevailed, or if the provisions of mental health law were properly applied.

Case-making mobilises the system for treatment

One female community mental health informant found it “much easier” to get her patients into residential care if she put them forward as involuntary patients. Another commented: “sometimes units are under the impression that in order to utilise certain resources they have to make the patient involuntary”. Another noted that “everything just seems to flow better” when a patient is admitted on an involuntary basis. These perspectives echo arguments in the literature for the practical importance of involuntary treatment orders, not so much because of their regulatory effect on consumers, but because they mobilise the service system (Churchill et al., 2007; Swartz & Monahan, 2001).

19 This is to distinguish it from the clinical concept of ‘case building’, which involves formulation of a model of factors implicated in the development of a patient’s condition that generates options for intervention (Winters, Hanson, & Stoyanova, 2007).
Case-making is ‘not hard’
That involuntary status was so easily achieved in their jurisdiction, considering the gravity of the intrusion involved, was a matter of surprise and concern to some informants:

Informant: I hardly need to build anything, to get an order. I do always put in terms of risk, because I think -

Interviewer: But even if they’re low risk—

Informant: You don’t have to mount an argument really. In the ten years I’ve worked here, I’ve had to mount an argument three times. I think I do, I try to do, quite good reports. I’m sure that they’re not that good, though... [emphasis original].

[Female, 40-54]

Informant: And it always seemed to me that it’s incredibly easy to get an order here compared to in [jurisdiction].

Interviewer: What were the sort of arguments used in [jurisdiction]?

Informant: I think the process was just much more stringent.

[Male, 25-39]

It would seem that case-making may not be a particularly difficult challenge, if the clinician decides that they want to treat, or at least wants treatment for, a particular patient, and if both patient and clinician are prepared to engage with the consequences of involuntary status to achieve access.

‘Creative’ case-making in practice.
Several informants reported that they had ‘flexibly’ interpreted and applied mental health law’s risk criteria, notwithstanding that the patient’s condition might not strictly satisfy it, but where the clinician had personally determined that treatment was necessary or advisable. The ‘creativity’ reported most frequently involved an enlargement of the level of risk, gravity of potential harm, and of the definition of mental illness to encompass the circumstances of a particular patient:

Informant: Yeah, yeah, but it also highlights the fact that actually to get into a hospital often it’s people who can create the most mayhem rather than people who need the specific treatment.

Interviewer: So does that create a sense of—Is it frustrating as a clinician, when you can’t make that pathway open? Does that increase your worry level or concern?
Informant: It makes you more creative.

I can build anything I want into the rubric of ‘serious harm’.

But I do think there’s a fair amount of flexibility. It’s written in a way that if you really think that [a patient] needs to be under the Act, you can make it happen. ... I think there’s sort of a bit of room to move.

Informant: Well it, sort of—what really happens is, you know, a lot of these people are high-risk, but they say: “Well, I’ve got five potential admissions at the moment and this guy is clearly the one we most want to get in a contained environment most quickly.”

Interviewer: What do you put in the records?
Informant: You say: “High risk of violence to others”.
Interviewer: And the other four people, you say...
Informant: You say: “No imminent risks to others”.

Case-making psychiatrists assert resistant clinical autonomy

Case-making practice occurs when the psychiatrist’s determination is at odds with the high-risk rationality underpinning mental health law, as well as with the ‘prioritise risk’, ‘manage scarce resources’ and ‘support and protect the service’ discourses. It is in this sense that the practice is resistant. Psychiatrists who admitted engaging in case-making practice exhibit supervening confidence in their own clinical discretion, and preparedness to ‘play’, if not to actively subvert, the risk-based system:

I guess it’s about—even putting aside the risk factors—there is a real lack of insight—and you’re wanting—you feel that somebody needs treatment for the benefit of their mental health—even if their lack of insight is not necessarily putting them at immediate risk. I think that you know if you are wanting to proactively treat somebody’s mental illness and they can’t really give consent, informed consent to the medication—if they don’t understand the sort of issues, about benefits of medication— and side effects—I guess those sort of things that are under ‘competence’. I think that for me that’s the absolutely essential criteria [emphasis added].
Personally I don’t use the imminence of risk per se as the fundamental reason. They need treatment and can’t be treated. Therefore they need to be admitted to get that treatment. Invariably, homeless people with major psychiatric illnesses don’t present an imminent risk. But they’re clearly untreated and they clearly need treatment and respond very well to treatment, but using a risk methodology...hospital gate keepers will say: “I don’t understand”.

**[Male, 40-54]**

Personally, sure. I mean I, not only do you have to kind of get around it, but sometimes you’re just obstructed by it inasmuch as you want to treat patients, but because they don’t have a gun pointed at someone’s head, they don’t get preference.

**[Male, 40-54]**

[There was] a case for me of a woman who I saw in private practice, who I’d known for a very long time and I knew that currently she was suffering a very severe relapse of a serious depression and that she was most likely, certain, to need electro-convulsive therapy to get her out of it. It seemed to me that the community crisis team could not see that diagnosis... I remember speaking with her on the phone and telling her that when the crisis team came next time, she had to tell them not only she wasn’t eating, but that she would starve herself to death unless she was admitted. *You almost have to coach people*... [emphasis added]

**[Male, 55+]**

The way I use it, it’s about selling, it’s actually like selling. You try and sort of present a person as needy as possible and so therefore that’s when the social issues come in.

**[Female, 25-39]**

....it’s more about what their need might be, and I think because I have a good relationship with them [the hospital] and probably because I don’t send them crap, I think they can sense if I say I think this person really needs an admission, because of A, B, C and D. I think the last person I sent to them was really not because of risk. I didn't think the risk was that great. But I think she needed to get out of the family and I couldn’t work out what was going on with her.

**[Female, 40-54]**

This determination to assert the primacy of medical discretion, notwithstanding the absence of legal rectitude, has been recognised by experienced commentators in the discipline of mental health law who have noted that changes or difference in the wording of involuntary treatment criteria may have little, if any, effect in practice on the decisions made by clinicians (Carney, 2008; Carney, Tait, Chappell, & Beaubert, 2007; Rees, 2007).
No matter what the law does, we’ll always treat all the people we want. I hate to say that, but that’s my experience. By hook or by crook…

(Morris, 2006, p. 30)

4.2.5.5 OTHER RESISTANT PRACTICES

The study identified other forms of resistant practice by psychiatrists, less strongly expressed than case-making and blame avoidance, which nevertheless involve assertion of the primacy of the interests of the patient and of the psychiatrist’s clinical discretion above hospital, risk-based care and other protocols. These included: rejection of risk-based treatment focus; asserting patient needs over hospital interests; rejection of responsibility for preventive detention; and ultimately, leaving the service.

Interestingly, but perhaps not surprisingly, older and more senior clinicians described more resistant practice than younger, less experienced practitioners.

Rejection of risk-based treatment focus, substituting non-risk-based treatment protocols

A number of informants, including senior and managing consultants, reported active resistance to, or even subversion of, the risk focus in their clinical units, urging a more holistic, ‘medical’ and individualised address to patient need:

I say it’s nonsense. Well, actually, I don’t say it’s nonsense. But I can and do say: “We don’t use the word ‘risk’ here in this service”. You can take a whole six months and we won’t have used the word ‘risk’. Well, actually, we will if someone mentions it. But we don’t use it. [Trainees] spend a whole six months in [my unit] and…they’re amazed that, far from missing out on things, the discussions here are much richer. They don’t use the concept of risk, and they come to think it’s kind of outlandish. But then they have to go back to environments where it’s all about risk.

[Male, 40-54]

Well—look, I’m not happy with all the risk—I mean I have… railed against suicide checklists which are supposed to tell you who is going to suicide and all that sort of stuff. I’m not happy with complex checklists which turn us into—I don’t know—turn us into mathematicians or something. …I just place them in a broad—I just put them under the Mental Health Act, and then let the registrar do all the bullshit that has to be done.

[Male, 55+]
Conducting ‘the war’: asserting patient needs over hospital pressures
Several clinicians, again mostly the more senior, actively resisted the pressure to align with
the state service and to comply with the risk focus, by identifying and aligning with patients’
needs over the requirements of the service:

Informant:  The clinicians here are, in a sense, ‘at war’ with the institution.
And so that the clinicians, unless they’ve been completely
suborned by the organisation, will be pushing to try to do what
they can, for the individual in front of them...But the hospital has
a different set of pressures on it... So there’s a constant struggle
and a constant tension that goes on or should go on and if it’s not
going on then my personal stand is that clinicians aren’t doing
their job...

I’m senior enough to be able to say “this is what I will do” and
“this is what I won’t do”. But for the more junior people they
will be pushed hard to use medicines in a way that minimises the
problems that the patients present. The problems that the
patients present with aren’t always [the same as] what they
need. A lot of them may have problems they present to the
organisation that aren’t problems they present to the world.
But then the organisation creates certain problems just by the
way they deal with the patient.

Interviewer:  What is the face of the thing, who is it that requires that things
be done in a certain way, in accordance with requirements of the
organisation?

Informant:  That’s an interesting question, you can’t localise that. It’s just
the ethic of the place [emphasis original].

[Male, 55+]

Rejection of responsibility for preventive detention
Informant psychiatrists demonstrated preparedness to substitute their own rationalities for
those transmitted by the state:

Interviewer:  So you were concerned about the use of the Act—

Informant:  Yeah. For like, preventive detention. I’m a doctor, so I will
treat. If you want to detain people preventively, you do that
under the legal system, not through me.

[Female, 40-54]

200.
Leaving the service
Psychiatrist informants reported that many psychiatrists decide to leave the public system in response to the range of pressures to which they are subject—including the pressure to treat with a risk focus, the pressure to align with the system over the patient, the pressure to manage with scarce resources rather than treat in a way they believe is more appropriate, and the pressure of likely blame in the event that something goes wrong. Resigning one’s position is a form of resistance to such pressures.

I don’t see it here, because I always run with beds empty and I have the flexibility if I want to keep people for two or three months so I can do a good job. One of the reasons I choose not to work in [adult psychiatry] is that I couldn’t, in good conscience, work in a system with those pressures.

[Male, 40-54]

People leave for all sorts of reasons, and people stay for all sorts of reasons... Because in the current set-up, you don’t do financially better outside the system. The system is well-paid. But there is a real tension between...what the organisation has to do to keep itself going, and what you, as a clinician, have to do to work satisfyingly.

[Male 55+]

In fact, not many people can stay longer than two years in the acute unit...the burnout and the toll of all the patients coming in and going out.

[Male, 40-55]

Informant: It’s one of the things that defines the difference between the people who stay in the system and the ones who leave...

Interviewer: Which is?

Informant: The feeling that they are acting as having to do this risk management on behalf of the larger community. Rather than the assessment and treatment of the patients.

[Male, 55+]

What does happen is that the clinician becomes exhausted, burnt out and unhappy in their job. A clinician does not feel that the job is professionally rewarding or that their good work is acknowledged. They come to feel that they are not doing something meaningful. This then becomes one of the reasons that clinicians abandon the public system and open a private practice.

[Female, 25-39]
Interviewer: It must be very difficult then when you’ve got lots of pressure to move people through and you know people aren’t ready to go, but you have to move them out...

Informant: It does drive many people out of the system.

Conclusion
In summary, the Phase III sub-study identified a number of practices of resistance to the range of incoming vectors of influence on psychiatrists from the state service. Many of these practices and discourses of resistance, and even of subversion, though arising initially as a response to an incoming vector of influence, can be viewed as expressions of influence of their own, as an expression of governmental flow (as discussed more fully in section 4.3 Governmental flow in assemblages). They are also examples of practices driven by what Lippert and Stenson (2010) refer to as ‘lower rationalities’. This push-back is pure governmentality-in-action: power moves, transforms and is transformed.

4.2.6 ACTIONS-ON-THE-SELF BY PSYCHIATRISTS

The second major class of responses to the state’s five identified vectors of influence directed at psychiatrists engaged by the state are, as identified in the Phase III assemblage schema, ‘actions-on-the-self’. This type of response is distinguished from ‘actions externally’ (to the self) most recently discussed, but also from ‘technologies-of-the-self’.

The difference between technologies and actions of the self
‘Actions-on-the-self’ do relate to ‘technologies-of-the-self’ however. Both engage the Foucauldian concept of the subject’s transformation of their self-identity. A ‘technology-of-the-self’, however, may form part of the strategy of an influencer to generate change in the subject that is consistent with the aims of the influencer. By contrast, an action-on-the-self arises in the subject as a response, not only to a technology-of-the-self, but to any of the technologies of power, and the vectors of influence they convey. It is likely that behaviour consonant with an action-on-the-self would not map precisely over behaviour generated by a technology-of-the-self projected by an influencer. As McKee (2011) has noted, the desired subject of a governmental initiative often fails to show up.
Obscurity in the genealogy of actions-on-the-self

The Phase III sub-study showed that informant psychiatrists did, indeed, undertake action on their self-concept in response to the influences exerted on them by the state. But it did not reveal clear relations between specific vectors of influence and specific actions-on-the-self. Though psychiatrist informants were able to distinguish, very particularly, the influences exerted upon them (often reported as “pressure to…”), they were less clear, overall, in reporting the effect of those attempted influences on their own identities.

This is not surprising considering that the technologies of influence sometimes demanded conflicting actions-on-the-self (for example, the requirement to accept reduced authority for decision-making and at the same time to accept blame for any adverse events that arise from them).

A subject’s action-on-the-self is also a function of antagonism between the rationalities of the incoming vectors of influence and the alternative rationalities harboured by the subject (Barnes & Prior, 2009; Lippert & Stenson, 2010; Lipsky, 1980; Morris, 2006). This is a complex, internal war. Self-awareness of the causal relation of any particular vector of influence on any particular action-on-the-self may not be possible. This is not to say that those relations do not exist but, certainly, that they cannot be recognised within the current methodology.

The Phase III sub-study found that, rather than generating specific responses to specific regulatory stimuli, informant psychiatrists adopted a coherent ‘position’ in relation to them. Individual psychiatrists established a conscious, personal stance in the power relationship with their employer, the state mental health service. This stance does not necessarily reflect a comfortable, rationalised state of being on the part of the subject psychiatrist but it does project cohesively, unlike the barrage of influences that are part and parcel of its creation.

Actions-on-the-self in three principal themes

As described in Figure 8, and in more detail below, the ‘positioning’ of the self by each informant psychiatrist in response to incoming influences was distinguished, in analysis, as belonging to one of three groups: ‘Acceptance’, ‘Positive Despair’ and ‘Negative Despair’.
The study found that ‘positive despair’ was, by far, the most common form of response by psychiatrist informants, with smaller groups exhibiting ‘negative despair’ and ‘acceptance’-type positions.

The positioning identified for each informant was derived by interpretation of the ‘affect’ displayed by the informant at interview and of the content of the transcripts of interview.

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‘Affect’ is defined as a set of observable manifestations of a subjectively experienced emotion: ("Affect," 2015).
4.2.6.1 ACCEPTANCE

Acceptance is a strategic position not capitulation

‘Acceptance’ positions were interpreted for individual informants who appeared to have reached a level of psychological ‘comfort’ in their relationship with their state service employer. They might continue to speak out against specific aspects of their working environment but on balance accepted the status quo. They were not, mostly, active in resisting specific vectors of influence, but if they were, their campaigns were delimited by desire to maintain positive relations with their employer overall. ‘Acceptance’ psychiatrists appeared to be relatively untroubled by the difficulties of public psychiatric practice asserted by others, as demonstrated in the following responses of two of the most apparently ‘resolved’ and senior informants:

I think, over a time, that sort of level of—angst or annoyance has probably lessened. I think we just sort of, I think the whole system in mental health is far from perfect and there is no intervention to solve the problem entirely, and whether the inpatient care or medication in the community or community treadmill or whatever—the nature of the beast is such that no matter what intervention one follows, it may have a less than satisfactory outcome. For all sorts of reasons. Something that you tried, that you've bended over backwards for—it ends up being completely useless, and not valued at all. It’s about being able to sort of work within the system...to ensure people get some sort of improvement. I suppose you just have to be tolerant of all sorts of outcomes, and accept that it’s not a perfect system, but if you can do a little bit of good for someone then that’s probably sufficient.

[Male, 55+]

I am part of the service because I choose to work here. I realise we work in an imperfect world and the service is also imperfect. I see my role as doing the best I can for patients within the system. At this point I do not see much point in publicly attacking the system I work for, hence my apparent compliance. However I will not tolerate being instructed to do things if I believe it is wrong, unprofessional or unethical. And if that leads me into conflict with the service then that is something I as an independent adult have to deal with. I can’t expect the service to make me feel OK all the time...But I think it’s awfully hard, in the current times, [for the community] to tolerate any sort of uncertainty... I do hold the opinion that have we to tolerate some of that for the well-being of the patients.

[Female, 40-54]

Some informants evincing an ‘acceptance’ position spoke of a mental health system that was found wanting in many respects, and especially in terms of the resources it had to
work with. Yet, this system they accept, or at least tolerate, in all its imperfection, not because they feel oriented positively towards it, but because they accept it as an unchangeable given and are deeply committed to helping their patients within it.

Acceptance of the ‘prioritise risk’ discourse
The study found that acceptance of the risk priority discourse tended to predicate acceptance in relation to other vectors of influence, such as de-professionalisation, for responsibility for risk management, and for involuntary treatment and detention:

I’d rather not spend so much time [at work] having to talk about the issue of the [involuntary order] and why the level of risk is so high or not so high. But I think that’s part and parcel of our jobs. If you separate that out—well, somebody has to do that particular part of it. I just see it as a necessary thing.

[Male, 25-39]

Basically what risk assessment does is mandates—you have a certain amount of information in front of you to move towards risk management. So as a high-level clinician, it’s relatively easy and quick, it’s in front of me, and I am confident in making a risk management plan... [If you have more information in front of you, you will make better choices in terms of clinical management.

[Male, 40-54]

Well, when I started out, I railed against the sociologists who called us ‘social janitors’ but as years went by I realised that they actually had it right.

[Male, 55+]

The relationship between compliance and acceptance
The results showed two sub-types within the ‘acceptance’ positioning: those who were genuinely compliant with the risk priority discourse, and those who tolerated it for the sake of doing what was possible, with a relatively modest estimation of their own capacity to make a difference to patient outcomes.

4.2.6.2 POSITIVE DESPAIR
What is positive despair?
The second and most populated position in the Phase III sub-study is referred to in this thesis as ‘positive despair’. Those psychiatrists expressing a ‘positive despair’ position are, like one of the sub-types of ‘acceptance’ clinicians, keenly aware of the faults of the system and passionately concerned to help their patients within it. Unlike that sub-group of
‘acceptance’ clinicians however, ‘positive despairers’ were less reconciled to the failings of the system, and less compliant with the state’s vectors of influence. They also appeared to suffer from a variety of forms of despair arising from their professional roles—and considerably more than those in either of the other two positional groups.

**Positive despair and the primacy of professional identification**

The Phase III sub-study found that those expressing a positive despair position constituted ‘the resistance’—being psychiatrists actively working to undermine hegemonic discourses such as ‘prioritise risk’ and ‘support and protect the service’ using the resistance-oriented practices, such as case-making, described previously. Additionally, however, the Phase III sub-study found that positively despairing informants rejected the self-identity promoted by the state’s ‘support and protect the service discourse’. As described in more detail in APP C.3 Technologies-of-the-self to this thesis, this discourse advances a professional identity in three elements including: ‘I tolerate risk of blame for adverse events’, ‘I accept reduced professional autonomy and respect’ and ‘I align with hospital values’. This resistance-oriented action-on-the-self is arranged around the strength of the informant’s sense of professional autonomy and their identification with being a doctor:

_I have a right in autonomy as a practitioner to say [how I will treat]… and in terms of who I see, and no one can actually tell me otherwise. So they can’t tell you what to do. They can sack you but they can’t tell you not to do it… It’s about professional autonomy saying: “I will use all my experience and try to dovetail with the services as much as I can”…but that general kind of policy, that’s ludicrous to adhere to that._

*Male, 40-55*

Quite frankly, after 15 years as a consultant and a PhD and whatever, and academic attachments, I have the confidence to express my point of view even if it’s different from any else’s point of view. I’d often be a single voice in a room or a couple would support me…At best all I can do is to introduce a kind of contrasting paradigm. It’s not all about risk; it’s sometimes about care. I just express my point of view, I can’t change what other people think. But what I can do is prevent it becoming the universal and only paradigm.

*Male, 40-54*

_I have—my style._

*Male, 40-54*

These clinicians, and their like-minded colleagues, appear to respond to the vectors of influence transmitted to them by the state, not in compliance but with a mind-set of settled resistance. The confidence to resist appears to be based in the autonomy vested in them by
their profession, and their senior and specialist status within it. They believe they know how to do the job the way it should be done, and have determined in themselves that the state cannot make them to do it differently.

To act ‘like a doctor’…

Closely related to assertion of professional autonomy, the second theme of resistance-oriented actions-on-the-self concerns the obligation to be doctorly:

I think for all of us—most of us—it would be: ‘I won’t have pleased everyone but I do feel I have done the right thing by my patients’… If you want to be able to sleep at night, you have to do the best for your [patient]—notwithstanding the system—and sometimes that is very uncomfortable.

[Female, 40-54]

There are many clinicians in [this city] who plough on and work as hard as they can to do the best they can for their patients in the face of all the pressures we talked about and this situation applies to the vast majority [emphasis added].

[Female, 25-39]

I’ve really, I have struggled with the whole adversarial nature of the [tribunal] reviews and stuff. In the sense that you’re on one side of the table, and there’s your patient with a lawyer the other side of the table. That is just so opposite as to how it should work as a doctor.

[Male, 40-54]

So things are really in a crisis mode. However if doctors, nurses, other allied health staff were to be more publicly vocal about that, one would be concerned that it might have repercussions for your job, it might be a conflict of interest.

[Male, 40-55]

Informant: Clinicians here are, in a sense, at war with the institution. And so that the clinicians, unless they’ve been completely suborned by the organisation, will be pushing to try to do what they can, for the individual in front of them… There is a real tension between the needs, what the organisation has to do to keep itself going and what you, with your clinicians have to want to do to work satisfyingly.

Interviewer: What are some of the things that you want to do, that you can’t?

Informant: Well, it would be to help people in hospital until you actually take care of the symptoms well enough, rather than just have them patched up well enough to get them out.
To act ‘like a doctor’ feels positive
Informants positioned in ‘positive despair’ evinced fervent determination to ‘be a good doctor’ pursuing a primary ethical maxim to align with their patient rather than the state. ‘Positive despair’ informants appear to accept a level of psychological discomfort as the price of this positioning.

Informant clinicians related their determination to be good doctors rather than good employees with quiet pride, passion and an abiding concern for their patients, and also thoughtfully, suggesting that this was a bearing they had come to, or resolved, over time and experience. To this extent, the resistance-oriented actions-on-the-self undertaken by clinicians positioned in ‘positive despair’ seemed healthy and self-sustaining.

Elements of despair
The same clinicians, however, described additional strong and negative emotions in response to the state’s conflicting vectors of influence. There were common elements of this despairing position explained by a large majority of the informants interviewed (if not in relation to themselves, then as they perceived in their colleagues). Informants spoke in terms of fear, anger, shame, guilt, confusion, sadness, stress and a general sense of being overburdened by pressure and responsibility:

Informant: In the short term, you have to struggle with anger, sometimes anger at your colleagues, because [this event] happened. There’s a lot of anxiety that—what if something went wrong?...There’s despair and guilt...[Then] you say to yourself: ‘If this was my sister, or brother or whatever—no way would I treat them like that!’ But because of the resource lack, you accept a compromise. No doctor wants to compromise on the best level of care you can provide to a patient [cries softly].

Interviewer: That is very moving [name]. Thank you very much.

Informant: I have to say it makes me very sad sometimes.

[Female, 25-39]

Fear of blame for adverse events
The study elicited the greatest number of expressions of fear and stress as arising in response
to the vector of blame for adverse events. Paradoxically, younger clinicians described their fear of making mistakes as a function of inexperience whilst older practitioners described the fear of making mistakes as a function of more experience:

I haven’t had any reason [to be the subject of inquiry] in the last, well, probably most of my professional life, but a number of my colleagues have, and it’s terrible. It doesn’t get any easier, just because you’re more experienced. If anything with more experience, I got more worried about sending these patients home.

[Female, 40-54]

But inevitably--it’s very hard to resist the cultural anxiety that is now around risk and the many legal aspects of that. So I think, even experienced clinicians, it hovers on their horizon...

[Male, 55+]

Not so much fear of the adverse event but of the reaction to it

Interestingly, it was the action of the accountability technologies such as the coronial enquiry and the surrounding social processes transmitting the pressure of blame, that generated the bulk of the reported, despairing emotions—not the actual suicide or other adverse event:

I say I don’t care but of course I do. Ashamed that every time you go to the shops and people say: “There’s that doctor that…”

[Female, 40-54]

People are petrified, absolutely petrified of going to the Coroner’s Court. This is the great, sort of, demonic fantasy in mental health, mainly in assessing the non-medical work. I don’t know, doctors are [accustomed] to being believed or something. You now we’ve all been residents or registrars, so we can stand up for ourselves to a certain degree… [But] like, there is this terrible fear—and quite frankly, when it happens, it is this awful experience for these people. They have to sit in the court dock for…days on end. Going through details and it all ends up in them coming across a list of questions that they can’t answer or are unable to answer. A list of things that they did or didn’t do.

[Male, 40-54]

I have known of people who underwent this process, it’s absolutely soul-destroying for these people, just such an unpleasant experience. The fundamental fear of all doctors is to avoid being in that position… It’s not just the coronial process. It’s partly political… and partly social as well. To decide if the decision you’re going to make is acceptable on all those levels, and who is

21 See sub-section 4.2.5.3 Resistance: Blame avoidance for discussion of the management of blame as a resistant 'action externally'. The current discussion features the action of blame internally, on the self-concept of the subject psychiatrist.
going to blame you if something does go wrong. It’s not just the coroner, it’s the patient’s family, your colleagues.

[Female, 25-39]

It seemed, in fact, that clinicians might just be able to cope with even poor outcomes of their professional decision-making if they were not so vulnerable to the effects of the blame levied upon them individually—not only by the state services and accountability processes, but also by their workmates and society more generally.

I think part of the pressure comes from the fact that you’re dealing with the illnesses in a general hospital setting. The psychiatric morbidity often is mysterious, less well defined than any other form of illness. You’re dealing with mysteries and you’re presented with the mysteries with enormous pressure to solve them so the unit can get on with this treatment. Otherwise you become part of the obstacle. If you can’t stop it... So I think there’s this enormous pressure.

[Male, 55+]

So, you know, [you hear]: ‘The [unit name] had to go to the coroner’s court about this murder. X, Y, and Z were thoroughly traumatized by it. And, you know, the coroner was very critical of us’. So it becomes... anywhere in the service, everyone knows about these experiences. [Everyone thinks:] ‘Thank god it’s not me. I don’t think I’d be able to cope with this’—on the soapbox, you know, having the tomatoes thrown at you.

[Male, 40-54]

We tap in on the obsession with risk that the world around us has... [But] it’s more the institutional response to a suicide and the coronial enquiry. This is more stressful than the actual event.

[Male, 40-54]

I think—fears of getting it wrong, fears of exposure. Fears of being condemned for getting it wrong. Perhaps some belief that there is an intolerance—this risk of exposure for mistakes in areas which one recognises is inherently difficult and where there is fallibility. I think we just live in a society now where we feel more vulnerable to scrutiny. That’s not a bad thing, professionals should be vulnerable to scrutiny. The overall aim is a good aim for society as a whole, but it places professionals under tremendous pressure and anxiety...

[Male, 55+]

Overall, views in relation to the professional despair of public psychiatrists were expressed with greater emotional amplitude than any other set of views arising from the Phase III sub-study:
The people who work here are just in an intolerable situation. They're being told: 'you can’t discharge people because they’re too risky'. But you must discharge people because there's another eight people in the waiting room!

[Female, 40-54]

Interviewer: Goodness. This is a hotbed this place.

Informant: It is. There’s a lot of deep-felt resentment and anger.

[Female, 40-54]

It’s very stressful. I told you I was in consultation liaison when I was doing my training, over 20 years ago. I remember...we were doing an academic course as part of the training. We would all go once a week to have tutorials and one component...was on personality. It was presented by a psychologist and she, at one point, gave us a little stress questionnaire. I thought she was kind of introducing us to the use of instruments to measure traits and responses and so on. At the time I’d been into my CL job for about 2 – 3 months, the one Consultation Liaison registrar in a 300-bed hospital that was covering emergency and all the wards. I can tell you—I was really stressed. I used to travel on the freeway to [facility name] and I had to get off at the [named] exit and every morning for the first two or three months I would just hope that the [name] exit would just not appear and that I could just keep driving up the [name] Highway forever. So there were about 16 of us in the class, we all did the stress questionnaire and CL was generally recognized as stressful rotation. Next class [the psychologist] said she had some feedback. She said: “I was really surprised. About 4 – 5 of these were rated at what I would consider a near death-level of stress”. I felt it was very interesting for two reasons. One was to discover that others—and I presumed that I was in that group—were feeling that level of stress. But secondly, that she was actually astonished! I realised that she just had no idea. Most people just don’t get it.

[Male, 55+]

Conclusion

The Phase II study found that a clear majority of informants had formed a ‘positive despair’ orientation in relation to the vectors of influence wielded upon them by the state, and most particularly, the vector of blame.

As its name suggests, the ‘positive despair’ orientation comprises two contrasting elements. The first is a positive, doctorly identity, encompassing self-confidence in an inherent professional authority, and a determination to act in the interests of the patient. The second element suggests damaging action on their individual psychological selves. This action comprises various possible elements of despair such as anger, guilt, sadness, but principally and pervasively, deep fear.

Overall, psychiatrists positioned in ‘positive despair’ reported more despairing, than
positive, action-on-the-self. Despite that they cared for their patients, and gained a sense of self-worth from doing this, I formed the impression that the net effect of the conflicting elements is negative and untenable in the long term, both for the individual clinicians and for the system overall.

I respect and honour the Phase III informant’s outstanding efforts to strive to be good doctors, and to help their highly vulnerable patients despite the huge, largely hidden and unrecognised pressures upon which this thesis has attempted to shed light. It is important that the damaging consequences of this particular assemblage of power relations within the Australian health system—damaging to those agents uniquely placed to ameliorate massive suffering and cost to our community overall—be recognised. At the very least, we owe them acknowledgment and action to reduce the levels of stress in their daily, working lives.

4.2.6.3 NEGATIVE DESPAIR

What is negative despair?

A third, and the smallest, group of clinicians were interpreted as occupying a ‘negative despair’ position. Unlike those positioned in ‘positive despair’, they took less or no satisfaction from their professional practice:

There are some clinicians who become so jaded by the system and feel so helpless that they then accept that very little can be done for the patient and start doing the bare minimum... A clinician can almost give up hope and accept that the patient’s symptoms are there to stay and that nothing can be done... They tend to not try anything new, or treat aggressively, or else just refer the patient [emphasis added].

[Female, 25-39]

Interviewer: How does that affect the clinician, that extra responsibility and lack of control? What impact does it have, in practical terms, on your approach to patients?

Informant: Generally, I find it uncomfortable and at times demoralising. I’ve tried to avoid it impacting on the way I treat patients—

Interviewer: So what do you think the impact of that despair is in the delivery of services to a patient?

Informant: I think there’s less—there’s a sense that people—there’s less sort of enthusiasm, I would say, about delivering a good service. I think there’s some—my feeling is there’s a sense of sort of
resignation almost to ‘this is the way things are’ and it’s not actually possible to improve things [emphasis added].

[Male, 25-39]

In the longer term I think you really develop a sense of helplessness and there’s almost, you almost get to the point where you think ‘is there any point in doing anything?’ It’s like a learned helplessness, you just think ‘I could do all this’ but is there any point? In the long term—I don’t know if other clinicians feel this way, but I do [emphasis added].

[Female, 25-39]

Clinicians positioned in ‘negative despair’ respond to the vectors of influence arising from their employment with the elements of despair described for the previous group, such as anger, fear and sadness, but with additional expressions of a deeper dejection, evincing helplessness, hopelessness, and an abiding pessimism about whether the system can be improved.

Changes in action-on-the-self over time

It is tempting to see ‘negative despair’ as a development over time from the more positive position, as the net effect of the two conflicting actions-on-the-self tend more and more to the negative, towards ‘burn-out’. Yet a number of the most despairing clinicians were amongst the youngest, and some of the clinicians positioned at the other end of the spectrum, in ‘acceptance’, some of the oldest.

The results of the Phase III sub-study, and particularly the polarity of the ‘negative despair’ and ‘acceptance’ positions, suggests two possible trends, over time, in actions-on-the-self by public psychiatrists. One possible dynamic is that acceptance-oriented clinicians, as their experience grows, become more tolerant of the system and of their own professional imperfections, less concerned about external judgment, more attached to their own autonomous, doctorly identity, and yet, at the same time, less confident of the centrality of their agency in patient outcomes. A second more negative cohort might, as they become more experienced, become less tolerant of their own and systemic imperfections, more stressed by external judgment and other pressures, and then start to distance themselves from a doctorly identity so as to minimise their felt agency in patient outcomes.
4.2.7 SUMMARY OF ASSEMBLAGE A1A RESULTS

This section has reported results of the governmentality analytic, conducted in the Phase III sub-study, of power relations between the state influencer and public psychiatrist subjects (Assemblage A1a). A pictorial summary of results for Assemblage A1a appears at Figure 3 in section 4.2 Assemblage A1a: State to Psychiatrists.

The study identified five technologies of power engaged by the state, often in harness, and directed to public psychiatrists. These were: the technology of employment, mental health law, the common law, accountability processes, and a technology-of-the-self, featuring attributes of a ‘good public psychiatrist’.

The study identified the dynamism of these respective technologies in conveying six specific vectors of influence. These included: the ‘prioritise risk’ discourse, the ‘align with the service’ discourse, the ‘manage scarce resources’ discourse; ‘de-professionalisation’, ‘blame for adverse events’, and ‘responsibilisation for compulsory treatment and detention’.

Governmental strategies inferred from the pattern and action of the technologies and vectors of influence, included strategies to: ‘minimise public dissatisfaction with access or the quality of service’; ‘minimise cost’; ‘minimise the incidence of adverse events’; ‘shift responsibility from the state for adverse events’, and to ‘provide limited access to mental health services for the highest-risk consumers’.

The four principal themes of governmental rationality identified through legal discourse analysis were: ‘provision of treatment and care’, ‘protection of the rights of consumers’, ‘protection of the community’, and a miscellaneous group.

Powerful additional objectives of government, functioning as genuine policy drivers, were found: to ‘minimise expenditure’ and to ‘minimise public criticism’.

From the perspective of the psychiatrist, actions externally to the psychiatrist in response to influence from the state were found to include compliant practices, such as gate-keeping practices, and care provision with a risk focus; and resistant practices, including: ‘blame avoidance’ and ‘case-making’, and also ‘rejection of risk-based treatment focus’, ‘asserting patient needs over hospital interests’, ‘rejection of responsibility for preventive detention’, and ultimately, ‘leaving the service’.
Additional psychiatrists performed actions-on-the-self in response to state influence. Psychiatrists' actions-on-the-self were respectively classified in three positioning: 'acceptance', 'positive despair' and 'negative despair'.
### 4.3 GOVERNMENTAL FLOW IN ASSEMBLAGES

People, just from the constant fact of shared space, become familiar with each other...I often feel that there is a certain 'inter-influence'. Not only do mainstream Australians press on to change the Aboriginal world, you sometimes find the Aboriginal world has a sort of—back pressure—on the world which comes to look at it and shape it.

(Adams, 2012)

As has been noted previously, the productive agency and counter-agency of subjects is a particular concern of this thesis, most particularly because it is able to point to otherwise invisible, ‘downstream’ effects of interventions. As a feature of governmental analytic, this is recognisable when power delivered by one vector of influence is re-employed—by the original subject—in another. This genealogical artefact sees the practice of the subject-in-response, and of the subject-turned-governor, mapped over itself. A likely original concept in realist governmentality scholarship, it is referred to as ‘governmental flow’ in this thesis.

Governmental flow can occur as a productive reflection of both compliant and resistant responses of the subject. New vectors of influence are generated—directed by the original subject either back at the original influencer or off to another actor entirely, to a new subject.

Governmental flow, in the case of a compliant response, engages the knowledge-power conveyed in the original vector of influence for productive action in a new assemblage. In compliant flow, the original subject adopts and proselytises to new subjects—in the form of new vectors of influence—the problematisation and rationality of the original influencer.

By contrast, governmental flow arising from a resistant response to a vector of influence signals the subject’s re-problematisation of the issue at hand, and substitution of an alternative or ‘lower’ rationality (Lippert & Stenson, 2010) for the rationality impelled upon them. This alternative rationality is utilised by the subject-turned-governor to fuel at least one new vector of influence, seeking either to ‘subjectify’ the original governor or another stakeholder entirely. In this mode, governmental flow is singular practice that both resists and exercises power. It instantiates battle between irreconcilable rationalities.

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22 Refer to sub-sections 2.6.1 Elements of governmentality assemblage and 2.6.3 Other specific analytic focii for more discussion about rationalities and governmental flow.
Notwithstanding its limited investigatory purview, the Phase III sub-study generated an amount of data pointing to governmental flow from both compliant and resistant responses. Sub-section 4.3.1 will briefly describe resistant governmental flow found in Assemblage A1b: Psychiatrists to the State. Sub-section 4.3.2 Assemblage A2a: Psychiatrists to Consumers will then briefly describe governmental flow arising in Assemblage A2a: Psychiatrists to Consumers.

### 4.3.1 ASSEMBLAGE A1B: PSYCHIATRISTS TO THE STATE

The dynamics of power moving from public psychiatrists to the state create a second and entirely separate genealogical assemblage, referred to in this thesis as Assemblage A1b: Psychiatrists to the State. Instantiations of governmental flow in Assemblage A1b are summarised in Table 10.

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23 For description of the methodological limitations, see sub-section 2.6.4 Research questions and limitations.
24 Though the method of the governmentality analytic permits inference in relation to the generative elements of practice and discourse forming part of governmental influence on the subject, the effect of that influence on the subject is, necessarily, an empirical concern. As noted previously, the scope of the Phase III sub-study was restricted such that the responses of the state, consumers and the community—as subjects—to expressions of influence exerted by each other, and by psychiatrists, were not accessible. Because of this lack of subject data, the governmental analytics in relation to Assemblages A1b and A2a, as well as to the A3 Assemblages, are incomplete.
Table 10
‘Governmental flow’ within A1b: Psychiatrists to the State

<table>
<thead>
<tr>
<th>Incoming Vector of Influence</th>
<th>Response/Outgoing Vector of Influence</th>
<th>Example of supporting data</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Prioritise risk’</td>
<td>Case-making</td>
<td>There’s no doubt that [psychiatrists] will exaggerate risk... They will exaggerate risk in order to get an outcome. It may not be the risk that is the reason they want a person in hospital. But they will play that up… [Male, 55+]</td>
</tr>
<tr>
<td>‘Manage scarce resources’</td>
<td>Blame management—by defensive practice (conservative risk assessment) and strategies to avoid patient engagement.</td>
<td>Int: But there are people not able to get in the door who go away - Inf: But those are invisible, those are invisible... Int: To you? Inf: Well, in a sense, to everybody… Somebody who comes to the door, can’t get in, gets sent away – that’s not going to be tied to your action, because there’s no data. [Male, 55+]</td>
</tr>
<tr>
<td>‘Support and protect the service’</td>
<td>Rejection of risk-based treatment focus, substituting non-risk-based treatment methods.</td>
<td>Int: How does that work out? Inf: … I’m less efficient. I take more time. People complain about that. [Male, 55+]</td>
</tr>
<tr>
<td>‘Support and protect the service’</td>
<td>Asserting patient needs over hospital interests</td>
<td>Inf: The clinicians here are, in a sense, ‘at war’ with the institution [Male, 55+]</td>
</tr>
<tr>
<td>Responsibility for compulsory treatment and detention</td>
<td>Rejection of responsibility for preventive detention</td>
<td>The last thing I want to do is go up… to [the tribunal] and sort of argue about you know how bad the person is, all that sort of stuff and how much risk they pose to themselves and others … it’s like: if we had any therapeutic alliance we wouldn’t need an order! It’s self-evident. The last thing I want to do is enforce, if I can get away it.</td>
</tr>
<tr>
<td>All A1 state-sent vectors</td>
<td>Leave state service.</td>
<td>Int: [So] you’re in constant war with the system, your professional urges are being thwarted - Inf: Yes, and like many, I’m leaving.</td>
</tr>
</tbody>
</table>
These results re-frame practices previously characterised as resistant responses by psychiatrists, as positive vectors of influence directed by psychiatrists back at the state. By these means, psychiatrists attempt to delimit the action of the state, utilising rationalities alternative to, and indeed competing with, those propounded by it.

The results suggest that, to convey these expressions, psychiatrists employ the technologies of mental health law, the privileges of delegated authority, and a technology new to the A1 assemblages, in the form of psychiatrists’ independent professional status. Like the clinicians in Kemshall’s (2001) study who rejected risk assessments that didn’t coincide with their own independent judgement, some of the clinicians in the Phase III sub-study are clearly accustomed to asserting their authority and autonomy in decision-making, notwithstanding concerted strategy of the state with the contrary intended effect.

The strategy that can be inferred from the practice and discourse arising in the data indicates, not mere non-compliance, but psychiatrists’ active subversion—of push-back on the state’s agenda. In engagement in these practices, psychiatrists engage the moral thrust of alternative rationality, proposed by them as superior to the state’s. At the heart of this alternative rationality is primacy of the therapeutic relationship, the traditional role of doctor and patient. A consistent message emerges. The ultimate objective of the resistant psychiatrist is to ‘be the best doctor I can be—to treat patients I wish to treat and how’.

4.3.2 ASSEMBLAGE A2A: PSYCHIATRISTS TO CONSUMERS

The Phase III sub-study found that new vectors of influence are directed by public psychiatrists to consumers in the performance of gate-keeping practices, the delivery of risk-focussed usual care, in defensive practices and in non-engagement.

These practices were originally identified as either compliant or resistance actions-in-response by psychiatrists to expressions of influence by the state in the results for Assemblage A1a. They represent instantiations of governmental flow in their renewed guise as vectors of influence in the A2a assemblage.

The technologies employed by psychiatrists in conveying these vectors included the use of mental health law in the gate-keeping, risk-focussed usual care and defensive practice expressions.
Figure 9
The genealogy of Assemblage A2a: Psychiatrists to Consumers
4.4 ACCESS-RELATED EFFECTS

The findings of the Phase III sub-study, as described in sections 4.2 Assemblage A1a: State to Psychiatrists and 4.3 Governmental flow in assemblages, and in Appendices B and C to this thesis, depict elements of the genealogy of power relations between public psychiatrists and three other stakeholders within the mental health law and access domain. Together, these results respond to the preliminary research questions, framing the broad field of enquiry, as identified at sub-section 2.6.4 Research questions and limitations.

It is important now to focus on the sub-set of those relations that are relevant to the principal research questions for the Phase III sub-study. These are:

How is risk-based mental health law deployed within the assemblages of power relations involving public psychiatrists?

and

How does this functioning affect access to service?

Deployment of mental health law within assemblages involving psychiatrists

The role of the technology of mental health law in the service of the various strategies of power exercised upon and by public psychiatrists, is contained within the results as reported and briefly discussed to this point. The specific points of involvement of the technology of mental health law is summarised in Table 11 below.
Table 11
Summary of findings: Elements of Phase III assemblages engaging mental health law

<table>
<thead>
<tr>
<th>A1a: The State to Psychiatrists</th>
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<tbody>
<tr>
<td>Vectors of influence employing the technology of mental health law</td>
</tr>
<tr>
<td>Responsibility for compulsory treatment and detention</td>
</tr>
<tr>
<td>‘Prioritise risk’ discourse</td>
</tr>
<tr>
<td>Responses generated by or engaging mental health law</td>
</tr>
<tr>
<td>Compliant and resistant ‘actions externally’ (expressed also as vectors of influence in A1b and A2a (for details, see below in this table))</td>
</tr>
<tr>
<td>Action-on-the-self: acceptance; positive and negative despair</td>
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<table>
<thead>
<tr>
<th>A1b: Psychiatrists to the State</th>
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</thead>
<tbody>
<tr>
<td>Vectors of influence employing the technology of mental health law (flowing with resistant responses to influence in A1a)</td>
</tr>
<tr>
<td>Case-making</td>
</tr>
<tr>
<td>Blame management by defensive practice</td>
</tr>
<tr>
<td>Rejection of risk-focussed usual care</td>
</tr>
<tr>
<td>Rejection of responsibility for preventive detention</td>
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</table>

<table>
<thead>
<tr>
<th>A2a: Psychiatrists to Consumers</th>
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</thead>
<tbody>
<tr>
<td>Vectors of influence employing the technology of mental health law</td>
</tr>
<tr>
<td>Gate-keeping (flowing with a compliant response to influence in A1a)</td>
</tr>
<tr>
<td>Risk-focussed usual care (flowing with a compliant response to influence in A1a)</td>
</tr>
<tr>
<td>Defensive practice (flowing with a compliant and a resistant response to influence in A1a)</td>
</tr>
</tbody>
</table>

Table 11 shows that mental health law features as a technology of power in three assemblages: in A1a: The State to Psychiatrists, in A1b: Psychiatrists to the State, and in A2a: Psychiatrists to Consumers.

Mental health law is also implicated in the responses of subjects. Responses in the form of ‘actions externally’ in Assemblage A1a: The State to Psychiatrists are reflected as vectors of influence in both A1a and A2a by the action of governmental flow.

It is noted that mental health law is implicated in both compliant and resistant responses of psychiatrists to incoming vectors of influence.

Responses to the incoming technology of mental health law in the form of ‘actions-on-the-self’ will be addressed in more detail in the discussion below.
Summary of access-resonant effects of the deployment of mental health law within the assemblages

The balance of this section will highlight and discuss the specific forms of the engagement of mental health law in the various assemblages that were found to resonate in effects on consumer’s access to service in the Phase III sub-study. These forms include:

- the ‘ordinary’ usage of mental health law;
- gate-keeping;
- case-making;
- risk-focused care;
- blame management by defensive practice, and
- informal triage.

4.4.1 Gate-keeping

Gate-keeping practices that engage mental health law

All of the types of gate-keeping practices revealed in the Phase III sub-study were described in the earlier sub-section 4.2.5.1 Compliance: Gate-keeping of this thesis. These practices were widely reported by informants in the study, representing one of its clearest results.

As a subset of the total list, the gate-keeping practices that engaged mental health law as a technology were:

- varying risk assessment practice with bed availability;
- flexibly interpreting ‘risk’;
- manipulation of the definition of mental illness, and
- applying a high threshold for the appropriateness of hospital treatment.

In all of these practices, provisions in the relevant jurisdiction’s mental health law are engaged to justify the denial or discontinuation of access to treatment.

Gate-keeping as a surreptitious purpose of mental health law

The current, Western model of risk-based mental health law arose in the 1970s from rights-based concerns. These metamorphosed, in more recent decades, to incorporate the rationale that the law facilitates treatment of those who would not otherwise engage or not
comply (Rose, 1985; Wales & Hiday, 2006; Winterton, 2007). But as Rose (1985) has argued, the rationalities for the regulatory intervention of mental health law may obscure more pressing political concerns. None of the Phase III jurisdiction mental health laws establish the rationing and distribution of scarce mental health resources as an express purpose. And yet, as coolly described by the following informant, this is precisely how the risk criteria are used in practice:

[W]e only have the resources to admit the patients with the highest risk. It’s a way of taking the top off—there’s plenty of extremely unwell people out there. There’s a much smaller number who are extremely high acute risk. Those are the ones who get the resources in an inpatient setting.

(Male, 55+)

The Phase III sub-study informants described overwhelming demand for services and the use of mental health law as a bulwark to the floodgates of that demand. The results show prominent use of mental health law provisions, such as the definition of mental illness, the least restrictive treatment provisions and the risk criteria—not to protect patients’ rights or facilitate their treatment but to justify refusal or discontinuance of treatment.

Gate-keeping as a function of an altered problematisation

It is clear that economic and social conditions have shifted since the current mental health law model was formulated. At the time of the instigation of the risk-based model of mental health, the recognised problematisation to be addressed by regulation was excessive medical paternalism. Now, as many commentators have observed (Donnelly, 2008; Freckelton, 2009; Lincoln, 2006; McSherry, 2008; McSherry & Freckelton, 2014), the principal problem in mental health is not coercion into unwanted treatment, but access to any treatment at all: “They must take what is offered or go unserved” (Wales & Hiday, 2006, p. 462).

Consumer responses to gate-keeping

Where there are limited clinical resources, patients are forced to compete, on criteria such as their relative suicidality (McArthur & Montgomery, 2004). There are external findings, also, that indicate that gate-keeping encourages ‘scamming’, with potential patients understanding ‘what works’ to gain access (Malone, 1998). This type of political response by consumers was suggested by psychiatrist informants in the Phase III sub-study:

...people start to buy into the language, and people say ‘well I have had thoughts of self-harm’ [emphasis original].

(Female, 40-54)
The focus here is not on adducing medical need, but on satisfaction of what patients correctly infer is the operative criterion—risk.

**External evidence of gate-keeping in health**

Evidence of gate-keeping practice in response to pressures to manage scarce resources, as found in the Phase III sub-study, is consistent with other findings of gate-keeping practice in public health service spheres. McArthur and Montgomery (2004, p. 491) identified an “underlying expectation” that the introduction of psychiatric nurses to the emergency ward would save on costs by prohibiting access to psychiatric beds. Bachrach found evidence of “preclusive admission policies” (Bachrach, 1987, p. 43), and Rosenzweig (1992) identified the practice of keeping potential psychiatric admissions waiting, in the knowledge that some would eventually just go away. Wales and Hiday noted that, in the new conditions of vast disparity between demand for service and available service resources, “decision-makers faced with the choice between involuntary hospitalisation or no action may be more parsimonious in committing” (Wales & Hiday, 2006, p. 463).

**4.4.2 CASE-MAKING**

The Phase III sub-study found considerable evidence that, despite the language of risk displacing professional tropes of diagnosis and treatment (Szmukler & Rose, 2013), many psychiatrists disregard the promulgated risk-based clinical protocols and, ‘subversively’, make decisions on a more comprehensive clinical basis. The phenomenon of case-making was earlier identified in sub-section 4.2.5.4 Resistance: Case-making as resistant action in which psychiatrists operationalised their determination to treat who and how they wished, through ‘creative’ application of mental health law risk criteria and definitions.

**Resistance to risk-based practice is evident in the literature**

The results of the Phase III sub-study in relation to case-making are consistent with the growing number of representations in the mental health literature of clinician resistance to risk-based practice (Holmes, 2013; Large et al., 2014; Szmukler & Rose, 2013). Hawley found, for example, that 76 per cent of UK clinicians surveyed said that risk assessment affected their clinical judgement less than 50 per cent of the time, and for around half of those informants, ‘almost never’ (Hawley, Gale, Sivakumaran, & Littlechild, 2010). This resistance archetype, the subversion of risk-based practice, may be an example of the
creativity expressed by the freedom-asserting employee subject to excessive regulation in the workplace as described by Szmukler and Rose (2013). An alternative theoretical model is Lipsky’s street-level bureaucrat who is driven by pre-eminent concern for the needs of service users to exercise discretion in their favour through the creative or flexible interpretation of regulation or policy (Evans & Harris, 2004; Lewis & Glennerster, 1996; Lipsky, 1980).

Similarly, McArthur and Montgomery described how emergency psychiatric nurses (EPNs) developed a political awareness to leverage patients they particularly wanted to help through the system:

This translated into assisting patients to navigate through the system according to their needs. Through navigation with a patient, the EPN [ostensibly] adheres to the value of gate-keeping while highlighting to the patient how the entry to the gate shifts…The challenge however is that the patient’s words and the experiences of the EPN need to be spoken in a manner that then cannot be turned against them or misconstrued

(McArthur & Montgomery, 2004, p. 497)

The results of the Phase III sub-study show that clinician discretion and political awareness is alive and well in Phase III jurisdiction mental health facilities, favouring patients who may or may not meet the eligibility criteria but, in any case, are fostered through the scarce resources ‘gate’ by patron clinicians.

4.4.3 LEGISLATIVELY SANCTIONED USE OF MENTAL HEALTH LAW

The need to consider ‘ordinary usage’

As identified previously at sub-section 4.2.3, one of the three major political rationalities for the risk-based model of mental health law is that it facilitates access to the services people need (Hale, 2007). Whether mental health law achieves this object is the principal concern of the Phase III sub-study.

Discussion to this point, on the use of mental health law as revealed by Phase III results, has largely focussed on practices that would not have been intended, foreseen, or sanctioned by the legislature. Results suggest that mental health law in practice is often engaged, not to facilitate access as its purpose clauses portend, but to restrict access—with programmes for the satisfaction of subterranean cost and electoral objectives clearly
flourishing within the assemblages of influence examined in the Phase III sub-study.

But the use of mental health law *in accordance* with the state’s expressed intentions is not closed-out by these unauthorised engagements. There is no doubt that, in addition to the more ‘creative’ uses disclosed, Phase III psychiatrist informants used mental health law on a compliant, workaday basis—invoking the authority of mental health law to provide treatment to people at risk of causing harm.

It is important to query, then, whether the ordinary, everyday, legislatively sanctioned use of mental health law provides a level of access that balances its unauthorised use.

**Does ordinary use of mental health law improve access for high-risk consumers?**

It is arguable that risk-based mental health law compelling treatment does improve access to mental health services for high-risk consumers (beyond the level of access that would pertain without the regulatory impact of risk-based mental health legislation), *but only if*:

- there are more refusing or incompetent, high-risk individuals in that cohort than high-risk individuals willing and competent to engage and comply with voluntary care; *and if*
- the risk criteria in the legislation and its accompanying technology (risk assessment and management protocols) were able to accurately identify the class of eligible persons; *and if*
- risk-focussed treatment, involuntarily-provided, improves the ongoing mental health of the consumer more than does voluntary treatment.

Each of these points have been debated extensively in the literature in recent decades with strong arguments developed against each of them.

With respect to the first point, Wales and Hiday (2006) demonstrated that safe, effective and assertive voluntary care would not lack for clients in the absence of coercive law.

With respect to the second, the base-rate problem has been shown to invalidate the risk assessment process (Szmukler, 2003).

Thirdly, studies involving ‘revolving door’, risk-based, involuntary admissions and CTO-based mental health service provision have failed to demonstrate any long-term health benefits flowing from the use of risk-based involuntary treatment orders (Churchill et al., 2007; Kisely & Hall, 2014). There is also evidence arising from the Phase III sub-study itself
that the risk-based, usual care provided under involuntary treatment is considered by many clinicians to be much less effective that a more traditional, holistic approach to clinical practice.

Perspectives from the literature in relation to the displacement of voluntary services, the base rate problem, and the therapeutic value of risk-focussed care are discussed in more detail in the next sub-section 4.4.4 of this thesis.

The argument that risk-based mental health law facilitates access to mental health service—even if the eligible class of recipients is restricted to only low-prevalence, high-risk consumers—fails on every necessary assumption. ‘Ordinary’, formally-compliant use of mental health law does not improve access for even high-risk patients because:

- there are so many even high-risk patients who would engage voluntarily (if they could);
- risk assessment technology cannot accurately identify genuinely high-risk patients; and
- the current regime for involuntary service provision—with its poor use of resources and its ‘revolving door’—cannot be shown to improve public mental health.

Thus, it cannot be maintained that even the business-as-usual, non-creative, legislatively-intended use of risk-based mental health law facilitates access to mental health services.

4.4.4 EFFECTS OF RISK-FOCUSSSED CARE

The Phase III sub-study findings support the conclusion that the risk-based criteria, as applied in practice, reduces access to mental health services via three principal mechanisms: (1) that low-risk categories of people with serious mental illness are rendered ineligible for public mental health care; (2) that the risk criteria cause significant damage to the therapeutic relationship; and (3) that the provision of risk-oriented care generates substantial opportunity cost in the absence of provision of more holistic, traditional, and individually appropriate care.

Low-risk patients are ineligible for treatment

Many informants in the Phase III sub-study noted their concern that the risk criteria circumscribe their clinical discretion so as to deprive needy, and yet low-risk, people of access
to mental health care. The types of would-be patient referred to included: troubled children; post-partum mothers; people with disabilities; homeless people; people with chronic mental illness and a co-morbid physical disorder or deterioration in need of ‘true asylum’; and ‘just the plain old nutty’ people who don’t pose a risk.

These views reflect the essential conflict of public psychiatrists who must perform in the service of the state, and for society at large, rather than for patients as they were trained to do. Their comments echo the views of ‘doctorly’ psychiatrists in the literature throughout the decades, including those present at the instigation of the dangerousness criteria in the late 1970s:

The concern is to make treatment available for people whose “free will” has given way to psychotic thinking and who are desperately in need of the best scientific care a humanitarian society has to offer. The mentally ill have a basic right to receive needed and appropriate treatment... Physicians and psychiatrists are better able to recognise the presence of mental illness than to predict the probability of future danger. They are better diagnosticians than prophets. If the goal of involuntary hospitalisation is to provide care for those who could benefit from it then to tie admission to potential dangerousness is inappropriate... The public interest is best served by handling mental illness as a health issue.... Psychiatric hospitalisations...are essentially medical decisions with legal implications...[emphasis added]

(Vincent, 1979, p. 335)

(and, as ‘resistant’ psychiatrists in the Phase III sub-study would argue, not the other way around.)

More recently, it has been recognised that the focus of resources on risk and coercion has reduced the availability of voluntary services for low-risk, and yet chronic, debilitating mental health needs (Wales & Hiday, 2006). It appears that in a minimally resourced mental health system, the development of a more appropriate and effective voluntary service system is postponed for its assumed higher-order of difficulty and expense (Wales & Hiday, 2006). Other commentators, too, have suggested that the resourcing of involuntary mental health services occurs at the expense of services for voluntary patients (Hiday, 2009; Lawton-Smith et al., 2008; Monahan et al., 2001). This is particularly worrying in the absence of clear evidence that involuntary, risk-based treatment programs, especially in the community, actually ‘work’ (Churchill et al., 2007; Kisely & Campbell, 2007a, 2007b; Kisely, Campbell, Scott, Preston, & Xiao, 2007; Kisely & Hall, 2014; Kisely, Smith, Preston, & Xiao, 2005; O’Brien, McKenna, & Kydd, 2009; Rugkåsa, Dawson, & Burns, 2014; Swartz & Monahan, 2001) and in the presence of evidence that increasing the availability of specialised, voluntary
mental health services in the community reduces the need for, and the incidence of, coercive strategies (Allen & Smith, 2001; Kallert, Rymaszewska, & Torres-González, 2007; Moseley, Shen, & Cochran, 2008; National Association of State Mental Health Program Directors, 2001; Substance Abuse and Mental Health Services Administration, 1999).

**Damage to the therapeutic relationship**

Several informants spoke of the damage caused by the risk focus to the therapeutic relationship between psychiatrist and patient. Although informants were divided about the anti-therapeutic effect of actual or potential coercive action per se, there was considerable agreement across the cohort of informants on the anti-therapeutic effects of the risk focus itself. Risk-based protocols addressing suicide, particularly, for which a number of informants were aware there is evidence of anti-therapeutic effect, provided a case in point:

I remember a junior registrar, now a very good consultant, questioning a patient who expressed suicidal ideation and he questioned him and interrogated him to make sure he had evaluated all the risks. “So [are you] thinking about doing this?” and “[Are you] thinking about doing that?” And: “What stopped [you] doing this at this particular time?” So [the registrar] kept finding ways to issue the suicide probe, which quite amazed me, over about two or three minutes. The patient finally said: “You’ve just got to stop. I’m feeling terrible. Ask me one more time about suicide and I’m going to throw myself out the window!”

I’ve got a guy who is very anxious, who has schizophrenia and a mood disorder. If you start asking him about suicide, he will start thinking about it. And he always has to say he is suicidal because [he knows] if he says he isn’t you might chuck him out. That’s his perception, and that’s what happened to him over 30 years of an illness. So now, I’m very careful about how I approach my risk assessments with him. I do it in a very subtle kind of way. Other people will be dancing in doing their checklists and so forth but this is just going to make him worse.

The Phase III sub-study results support the assessment of Szmukler and Rose (2013), and others, that the risk focus critically injures patient trust in the clinician. There is consequently less willing engagement and compliance by patients, less time to establish rapport and overall, and less time and energy for developing individualised treatment plans to address the idiosyncratic needs of every individual consumer.

**The opportunity costs of risk-focussed usual care.**

What sort of treatment is displaced in practice by risk-focussed usual care? This question has been extensively debated in the literature, with proponents of risk-focussed usual care
asserting that, on a population basis, the risk focus directs treatment to patients with the greatest need (Dolan & Doyle, 2000), as against a growing chorus of ‘risk-busting’ clinicians who argue that the risk focus precludes other more productive forms of treatment such as building rapport with the patient, understanding their history, helping them with substance abuse, and developing and advancing medication adherence strategies (Large et al., 2014; Large et al., 2011; Mossman, 2006; Szmukler & Rose, 2013).

A number of Phase III clinicians, and particularly the more senior, echoed the sentiments of the latter group, describing how the risk focus actively damaged and narrowed understanding of what is appropriate, professional psychiatric care and treatment:

You also have to try and engage people in a kind of discussion about what’s our function. I’ve heard this—this has been said a number of times recently. I don’t agree with it. It drives me nuts—“the function of mental health is the assessment and management of risk”. I say: “When I went to medical school the function of medicine was the care and treatment of people, the assuaging of suffering”. So the whole paradigm has shifted from a kind of caring one, to a kind of preventative, ‘stop bad things happening’-one.

I think sometimes it comes through with junior psychiatrists beginning to lose the ability to differentiate between thought and action, which is sort of fundamental to developing psychiatric understanding. What I mean by that is that patients who express suicidal ideation are immediately seen as a highly at-risk group, when a more experienced psychiatrist would understand that expression of the ideation of suicide, is actually a common pathway for a complex array of impulses, wishes and needs. Some of them are actually reflecting a capacity to deal with something that is barely tolerable rather than indicating intention to act.

I think that we—it’s almost become a bit of a sort of separation-out of significant mental illness psychopathology and risk and I think that we...run the risk of missing the kind of mental illness, because we get too focussed on the risk thing. Whether somebody can guarantee their safety or not... It is interesting because—you know, we don’t have a kind of form to assess, say, whether our clinician’s established a good rapport with this person.

These views are consistent with McArthur’s (2004) description of risk-focussed psychiatric practice as an unhelpful form of dualistic, linear thinking that is unlikely to lead to a solution to such a complex problem as a mental health condition. Szmukler and Rose, also, identify that the focus on risk assessment and risk management displaces “older kinds
of expertise” (Szmukler & Rose, 2013, p. 132). Holmes (2014) suggests that the role of psychiatrist in the multidisciplinary mental health world is refining towards sole specialism in risk assessment and management, reflecting an entirely misplaced confidence in the psychiatrist’s capacity to prosecute this role effectively.

Furthermore, and according to a growing number of authorities, approaches founded in risk assessment are unlikely even to be effective at their intended purpose—the identification of patients likely to commit a serious, dangerous act—because the base rates of the incidence of such acts in the relevant populations are so small (Dawson & Szmukler, 2006; Hayes et al., 2007; Langan, 2010; Large et al., 2011; Szmukler, 2001b, 2003).

Such views were supported by a number of Phase III sub-study informants, who expressed the view that a more traditional, broader treatment style actually works better to reduce the incidence of adverse events than the more narrow risk-focussed practice mode supposedly designed to specifically address this:

What you [used to do] was: “The patient's unwell, what’s the best way of managing his interests?” I believe...that that is actually far better than reducing adverse outcomes than this risk focus.

[Male, 55+]

Several informants expressed concerns that the population-health basis of the risk focus discouraged attention to patient individuality: Risk itself becomes a barrier in understanding, in appreciating who the person is.

[Male, 40-55]

You don’t get to know the person behind it if you just do a risk assessment. You just become an actuary.

[Female, 40-54]

These concerns reflect Silver’s observation that a risk-focussed service system:

…does not feature impaired individuals in need of treatment. Rather, it features a systemic program aimed at separating the less from the more dangerous.

(Silver & Miller, 2002, p. 148)

One senior manager, however, argued strongly for the value of a population-health perspective, even for individuals:
[Population health]—that’s the stated aim of our government department. On the front page of their website. I wouldn’t guarantee that it infuses the way we operate, I wouldn’t guarantee that it infuses all of their funding and thinking. But that’s what that is... To be honest, I think it’s a fair bit easier to manage at the population level. But also an individual level. As in—most people in those situations conform to standard response rates. I’m talking about response, not just medication. But psychological response to those events as well. Most people have a fairly standard way of conforming to that. Such as, the vast bulk of people who attempt suicide don’t die by suicide. So, you know, you are sort of helped by relatively low prevalence and relatively low event outcome. So it’s proved true across the whole illness or the whole lifespan from that point of view. But it’s still risk.

A number of clinicians, including several who felt that a risk focus was ‘part of care’, specifically mentioned the opportunity cost of the risk focus, in the context of the powerful combined effect of the ‘prioritise risk’, ‘manage scarce resources’ and ‘support and protect the service’ discourses:

So much time is spent on documentation of your risk assessment that I would think it would be so much better spent doing other things. So I agree that the risk assessment takes time, but not because of the actual assessment, it’s the documentation.

Informant: And then the documentation of what decision you make so that it looks acceptable...

Interviewer: That takes away from the patient care?

Informant: Absolutely. I could be doing so much more else than justifying why I’ve made my decisions—

Interviewer: What sort of proportion of time do you think you would spend justifying decisions?

Informant: I would say at least 50% of total interaction time at least and possibly more. That’s the most unsavoury aspect of my job here. Just the documentation. Making sure things look good.
What happens [here] is [that] a person is put on some sort of [temporary order] and then there’s a great flurry of faxing—this, that and the other thing—and nurses can’t be there to check the patient, they’re all faxing and checking this shit. The next thing is a week or so later, you’ve got to be in the tribunal... I’m not interested in this crap. [I’m interested] in the real mental illness, but I’m not interested in waiting around for my registrar to come back from the tribunal after half a day arguing with law students. It’s just degrading.

[Male, 55+]

And I think it does take away from some of the things...including a better assessment of the illness, and of the person that the illness resides in, to determine what you’re going to do in terms of treatment.

[Female, 40-54]

A number of informants remarked on the negative tenor of the risk focus and the resultant cost in terms of loss of positive vision for clients and for treatment alternatives:

[We used to make] decisions based on the benefits and consequences. [These were] risk-benefit analyses. Whereas at the moment the analyses are just risk analyses, so that it’s not weighted against the benefits. “I’m just focusing on the risks. There may be no benefit in this but I’m just going to focus on the risks”...There’s always some risk in a particular pathway. But if you are fundamentally phobic about risk, you are always going to choose the pathway that is least likely to lead to a major adverse event which exclude a whole lot of other pathways which might be much better for the patient [emphasis original].

[Male, 40-54]

I think that with a lot of the young people—we end up erring on the side of caution, ultimately to the detriment of that young person...We lose an opportunity to build resilience in kids. We lose an opportunity to build resilience with families in families and in broader systems. We take that sort of fairly short-sighted [perspective]—“We need to take this decision now because that would mean we can go home to bed and go to sleep. Somebody else can make the decision the next day”. But I think that we pay the price later.

[Female, 40-54]

These findings in relation to clinicians equalising attendance to vulnerability and resilience characteristics are consistent with the results of the study conducted by Langan and Lindow (2004), in which a number of professionals reported the practice of always including positive, resilient characteristics of consumers alongside the negative characteristics in their risk assessments.
Conclusion
It has been claimed that risk-based mental health law authorises and substantiates a risk-based service norm that ‘works’ to disconnect public psychiatry from its medical ideals (Brophy & Savy, 2011). The Phase III sub-study supports this conclusion, finding that control of risk of harm is valorised above effective treatment of illness.

The Phase III sub-study found for the existence of an overarching and infrequently challenged discourse that psychiatric risk management is one and the same as care and treatment for mental illness. The duty of care (of a patient) has in fact become merged with a duty to control (a risky unit of population). The risk-focussed treatment norm does not merely co-locate, or even equate, concerns about care and control. Rather, it conflates them (Rosenman, 1998). The irony of this was clearly not lost on some psychiatric nurses in Hazelton et al’s (2011) study, who quite cynically used the term ‘duty of care’ to justify heavy-handed, and yet time-efficient, patient control measures. Despite their lack of humane concern, their recognition, at least, of the duality of care and control, is in some way more heartening than the blind assimilation of the concepts in the risk-focussed usual care mentality.

The Phase III sub-study encourages renewed appreciation of the deceit of the conflation of care and control. It confirms Brophy’s (2011) and Sawyer’s (2011) conclusion that risk-focussed service takes place with great opportunity cost in the provision of more innovative, holistic, human-centred care. It confirms Matt Large and colleagues’ (2011) conclusions that vulnerable, chronic and non-risky patients are afforded a marginalised treatment priority. The Phase III sub-study has demonstrated how, in practice, a ‘risk+control’ consciousness has effectively hijacked the therapeutic relationship—its input, its outputs and what goes on in-between.

4.4.5 BLAME MANAGEMENT

The Phase III sub-study highlights counterpointed blame influences exerted on psychiatrists—in the form of pressure to support and protect the state services from blame, and pressure to accept blame personally for adverse events. Informants reported compliant actions-in-response to the first pressure in the form of risk-focussed usual care practices, which included defensive practices for the benefit of the state. They also reported resistant responses to the second in the form of defensive practice in their own interests, and by
avoiding patient engagement. Psychiatrists also reported levels of stress and despair which were closely associated with fear of blame. Each of these responses resounded with effect on access to mental health services, and each involved mental health law, either as the technology of the incoming vector or as part of the psychiatrist’s blame management action.

**Despair and the ‘culture of blame’**

Informants’ actions-on-the-self in response to the influences exerted upon them in their work were classified into three groups: ‘acceptance’, ‘positive despair’ and ‘negative despair’. Informants in the largest of these groups, ‘positive despair’, valued fidelity to their doctorly instincts, preferring their patients’ needs over other competing interests. Along with those in the ‘negative despair’ group, however, they reported regular experience of strong and uncomfortable emotions such as anger, sadness, guilt—or most frequently and simply, ‘high levels of stress’.

As noted previously, one of the biggest pressures experienced by Phase III informants was the pressure of possible blame for clinical decision-making leading to adverse events, with an overwhelming majority of informants (26 of 28) reporting ‘damaging’ levels of pressure to avoid adverse outcomes. This result accords with views expressed about psychiatry’s ‘culture of blame’ in the literature (Firth-Cozens, 2007; Holloway, Szmukler, & Carson, 2000; O’Connor et al., 2011a; O’Connor et al., 2011b).

**Despair minimises quality of service**

Informants in the despair groups reported that the experience of these despairing emotions reduced their energy, creativity and optimism in their therapeutic relations with their patients. They also reported instances of seeking to avoid engagement with patients, or with certain patients at least, and spoke about leaving public practice as a real, future option.

These results are consistent with research on the ethical and psychological response of psychiatrists to their working conditions. The phenomenon of ‘moral distress’, being the negative feeling experienced when necessary action or inaction conflicts with a person’s ethical norms, has been identified as particular feature of public psychiatric professional practice (Austin et al., 2008; Austin, Rankel, Kagan, Bergum, & Lemermeier, 2005; Sheehan, 2009). Stampfer (2011) and Kumar (2011), also, cite stress in the workplace as a reason for falling global recruitment to the psychiatric speciality. Firth-Cozens (2007) found that psychiatrists were at particularly high risk of developing alcohol and drug related problems, suicide, and burnout.
The effect of defensive practice on access

It has been recognised that, from time to time, forms of defensive practice (such as, say, a delayed discharge) might have protective or pro-therapeutic effect for patients, notwithstanding that the motivating reason for the practice is medico-legal protection (Mossman, 2009). Because the essential element of defensive practice is medico-legal protection, however, it mostly does come with detriment to the patient:

Members of the Scoping Group and psychiatrists responding to the College survey reported that risk was dominating their practice. They argued that they were increasingly expected to function as ‘agents of social control’, which was having a damaging impact on their clinical practice, undermining meaningful clinical decision-making and making engagement with patients more difficult…

Informants perceived these consequences as politically driven, with 83% of participants agreeing that risk assessment now took place in a political context in which concern for public safety had taken political precedence over the welfare of those suffering from mental disorders [emphasis added] (Kennedy, 2008, p. 21)

Phase III informants reported that the principal effects of risk-focussed, defensive practice included: first, that needy patients not assessed as high-risk were not likely to receive treatment; and secondly, that the risk focus reduced scope for creative treatment approaches, for option-testing, and for clinical attention to individual patient differences. These findings are consistent with other studies in a large body of literature critical of the effects of the risk focus on the quality of public psychiatric practice (Langan & Lindow, 2004; Large et al., 2014; McArthur & Montgomery, 2004). Other types of defensive practices identified in the Phase III sub-study included: non-admission; admissions or discharges decided with a view to media exposure; excessive documentation; hand-balling or turfing; deciding to leave public practice altogether, and the use of documentation such as suicide checklists principally designed for medico-legal purposes. In that all of these practices have the effect of reducing the availability of timely, appropriate and effective treatment, they have a negative effect on access.

Mental health legislation is implicated in blame management practice in public psychiatry as the central set of norms governing, and in fact requiring, risk-focussed treatment and care. Risk has the additional ostensible benefit of providing a basis for assessing the performance of psychiatrists (S. Scott, Jones, Ballinger, Bendelow, & Fulford, 2011; Szmukler & Rose, 2013). Measurable accuracy and thoroughness in risk prediction, and a managerial approach to distributing care based on risk categories, has been described
as a new standard for the provision of effective mental health service, rather than
‘unquestioned expertise’ in psychiatric professionalism (Kemshall, 2000). It provides a basis
in medico-legal protection both for individual psychiatrists and the state service (S. Scott et
al., 2011). As a substantiating process for selection of only the most dangerous units of
population for treatment and medicalised control, risk appears to be a relatively cost-effective
utility to protect both the public and the individual patient from harm.

The Phase III sub-study confirms perspectives in the literature that conservative,
defensive, risk-focussed practice results in a narrow, sub-optimal and overly-restrictive
treatment for true and false positive patients, and under-servicing for true and false negative
patients (Langan, 2010; Large et al., 2011; Munro & Rungay, 2000). Mental health law is
the operative technology that establishes these statuses, and the negative treatment and
access implications that flow from them.

4.4.6 INFORMAL TRIAGE

Surprisingly little is known about the process used by Australian mental health facilities to
manage the allocation of scarce clinical resources in the context of high demand (Grigg,
Herrman, Harvey, & Endacott, 2007; McGorry, 2010; Rosenberg et al., 2012). The Phase
III sub-study has thrown some light on the everyday mechanics of how mental health
facilities select consumers for treatment.

Under the category of gate-keeping, it found that clinicians undertake a range of
practices, including through use of mental health law provisions, to restrict access to public
mental health services. Case-making practice works in the opposite direction, by negotiating
access for patients who clinicians wish to treat with arguments built on the risk or definitional
provisions within mental health legislation.

What is triage?
The ‘triage’ concept originated as a medical care system in the Napoleonic Wars (Robertson-
Steel, 2006). It refers to the sorting or categorisation of patients for treatment priority
(“Triage”, 2015) The formal triage protocols in Australian mental health units are founded on
the risk-of-harm criteria, clinical need and ‘determination of acuity’ (Grigg et al., 2007).
These criteria roughly coincide with ordering mechanisms explicit in mental health law. But
when risk, need and acuity are rife, and all comers satisfying these cannot be served, further
additional rationing criteria become necessary. Gate-keeping and case-making practices, as described above, are examples of ‘informal’ triage practices engaged for higher-level sorting when demand for services—from needful, eligible patients—exceeds supply (McArthur & Montgomery, 2004).

**Informal triage in the literature**

The Phase III findings of informal triage practices are consistent with the literature developed from Lipsky’s description of the operative discretion of ‘street-level bureaucrats’ (Lipsky, 1980). Evans and Harris (2004) reviewed the processes of discretion exercised by front-line social service providers. They found that professional discretion was utilised creatively to ‘make room’—as in case-making—and to protect it, as in gate-keeping. They reported that professional discretion could be used in the interests of consumers, or against them (also Baldwin, 1998; Horwath, 2000). Jecker (1996) describes covert, bedside rationing which is implicit and unavoidable when explicit policy doesn’t determine who should be treated if all cannot be. Ellis et al (1999) describe social professionals’ compliance with pressure from managers to exercise discretion so as to ration scarce resources. Evans and Harris (2004) found that the possession of discretion may be denied so as to avoid its exercise and the possible downstream outcomes, like blame.

There has been explicit recognition that legal and medical practitioners in the mental health field utilise criteria in decision-making “without formal definition”—such as the notion of insight, and non-compliance (Richardson, 2010, p. 191). Freckelton (2010, p. 229) refers to the “problematic gap between considerations actually taken into account…and the considerations formally stipulated…by legislatures”, where the “considerations in the real world…function as free-floating, de facto yardsticks”.

**The criteria used in informal triage practices**

The Phase III sub-study found for the existence of informal triage practices of case-making and gate-keeping using the criteria listed in Table 12 as reported by Phase III psychiatrist informants. These informal criteria overlap significantly with those identified by Jecker (1996).
Table 12
Informal triage criteria reported by Phase III psychiatrist informants.

<table>
<thead>
<tr>
<th>Informal criteria for case-making (to screen patients ‘in’, whether or not the formal criteria are met)</th>
<th>Informal criteria for gate-keeping (to screen patients ‘out’, despite that the formal criteria are met)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical benefit of treatment to patient.</td>
<td>Presence of dementia.</td>
</tr>
<tr>
<td>Social vulnerability.</td>
<td>Patient has abused substances.</td>
</tr>
<tr>
<td>Political or social importance of patient.</td>
<td>Patient is difficult to deal with.</td>
</tr>
<tr>
<td>Media interest.</td>
<td>Patient has chronic, untreatable mental illness.</td>
</tr>
<tr>
<td>Treatability—of the condition, of the patient.</td>
<td>Patient is not at ‘imminent risk’ of causing harm.</td>
</tr>
<tr>
<td>Historical therapeutic relationship.</td>
<td>Patient is elderly.</td>
</tr>
<tr>
<td>Pressure from family or carers.</td>
<td>Patient is homeless.</td>
</tr>
<tr>
<td>The absence of ‘insight’.</td>
<td>Personality disorder.</td>
</tr>
<tr>
<td>‘Real’ mental illness.</td>
<td>Intellectual disability.</td>
</tr>
<tr>
<td>Presence of dementia.</td>
<td>Patient with complex problems.</td>
</tr>
<tr>
<td>Patient has abused substances.</td>
<td>People in ‘temporary’ crisis.</td>
</tr>
<tr>
<td>Patient is difficult to deal with.</td>
<td>People retaining mental capacity.</td>
</tr>
</tbody>
</table>

Phase III results suggest that where the medico-legal criteria for access to mental health services does not effectively mitigate formally eligible demand to meet supply, psychiatric clinicians apply additional sorting criteria, according to their own discretion or the culture of the workplace.

The tenor of these additional criteria is consistent with Malone’s recognition of the importance of ‘legitimacy’: patients who are not able to present with ‘acceptable’ medical problems, and with preparedness or inability to comply, can be designated as ‘illegitimate’ service-seekers (Malone, 1998). Several other of the informal criteria—including indigence, intellectual disability and substance abuse—suggest the impact of an abiding service management concern with decelerated ‘patient flow’, despite the presence of genuine co-morbidity or dual diagnosis.

It should be noted, however, that there was no evidence in the Phase III sub-study supporting the use of the specific, informal criterion the focus of Jecker’s study—social worth (Jecker, 1996). Rather, Phase III informants suggested that low social worth was more, rather than less, likely to result in access to service.
What’s wrong with informal triage?
It is arguable that the use of the types of informal criteria identified, for the sorting of ‘excessive’ demand, or to secure service for particularly needy, if not particularly high-risk, patients, is a reasonable and just application for medical discretion. Yet there is a strong case for its inappropriateness. Freckelton expresses concern that the informal criteria are:

…less than transparent…imprecise and confusing. There is a risk both that they will function…as sanist conduits for unarticulated paternalism and they they will overtake (or at least interact unclearly with, or even contaminate) the criteria that are legislatively prescribed.

(Freckelton, 2010, p. 229)

Similarly, informal triage, Jecker (1996) argues, is spur-of-the-moment, not consistently applied, not accountable, not insulated from arbitrariness, and of course, not sanctioned nor overseen by the legislature, by the wider community, by a professional association—not, in fact, by anyone

Significant findings within the Phase III sub-study point to the strategic, and yet inappropriate, use of mental health law in additional, informal triage practices such as case-making and gate-keeping. These practices have direct impact on the distribution of access to mental health services at the time of their performance. There are broader implications, however, such as the abdication, by the larger society, of its responsibility for fair and conscious decision-making about the rationing of scarce health resources (Jecker, 1996).
Methodology

The Phase III sub-study was a qualitative, ethnographic research project utilising a realist governmentality analytic method. It addressed the practices of public psychiatrists engaging mental health law within assemblages of power relations between psychiatrists and state mental health services, consumers and the general community respectively.

The study was conducted in five Australian mental health law jurisdictions: New South Wales, Victoria, South Australia, Tasmania and the Australian Capital Territory. Twenty-eight interviews with public psychiatrists were conducted; the majority were recorded and transcribed. There was additional discourse analysis of mental health law and policy documentation. Interview notes, transcripts and discourse analysis product were coded thematically and with a view to elements of a genealogical analytic: the influencer’s rationale, objective, strategy (with its sub-element, vector of influence), technology, and the subject’s responses in the form of ‘action externally’ and ‘actions-on-the-self’.

Limitations

The principal limitations of the study arose principally from the restricted time and cost conditions of the unfunded, doctoral candidature under which it was conducted. There was capacity to investigate in detail the practice of only one stakeholder. This meant that data was collected on the influence and the responses of only the psychiatrist stakeholder in each of the three dyads. This restriction limited the range of genealogical inferences significantly.

Fortunately, discourse analysis was able to supply relevant data about the state’s governing intentions in Assemblage A1a: The State to Psychiatrists, with a relatively comprehensive genealogy resulting. To achieve a similar level of completion in other sets of assemblages would have required ethnographic fieldwork with community and consumer informants. This was not feasible within the design limitations of the study.

A second possible limitation arose from the inability of the method applied—related to the semi-structured interview format or the content of the questionnaire—to produce data amenable to more precise analysis of the causes of psychiatrist stress and despair. Alternatively, perhaps the linking of specific causes and effect in terms of the psychiatrist’s actions-on-the-self was an unrealistic aim. The pressures on public psychiatrists to be, do and think in certain ways are many, and they come from several directions at once.
Preliminary research questions—the genealogies.
The preliminary research questions, as detailed sub-section 2.6.4 Research questions and limitations, required conduct of a genealogical analytic on each of three dyads of power relations involving public psychiatrists, identifying and inferring elements of assemblage—with particular concern to identify gaps between governmental rationalities and objectives; and secondly, to discern the productive power of the subject response in instantiations of governmental flow within and between assemblages.

The purpose of this preliminary stage of analysis was to gain understanding of the overall field of relevant power relations to enable more specific theoretical analysis in relation to the role of mental health law and the access effect.

Despite the limitations on its scope, the study did produce a comprehensive picture of the governmental pressures to which psychiatrists are subject. Figure 10 summarises the content of all of the vectors of influence—in the form of both practice and discourse—directed to public psychiatrist by the three stakeholders investigated.

The quality of the influences are notable in that, for the most part, they attempt to direct psychiatrists’ practice and self-concept away from the profile of doctorliness in which they have been trained, and as pertains for most doctors other than public psychiatrists.
They are notable, also, in their number and range, and for the inherent conflict and illogicality amongst them. For example, the pressure of ‘patient social and clinical need’ is applied alongside ‘prioritise risk’ with no true rationalisation possible. The community—impossibly—expects psychiatrists to prevent adverse events. It is not surprising, therefore, that participating psychiatrists reported outstanding levels of work-related stress.

The study exposed two significant paradoxes within relations between the state and public psychiatrists which highlight the strength and difficulty of pressures within the working environment of public psychiatrists.

The paradox of increasing risk by being risk averse
In the first, it was ascertained that, though state services appear to have a pre-occupation with reducing and managing risk, practices engendered by scarce resources (such as early discharges and non-admissions), and by the risk focus itself (such as iatrogenic and time-consuming documentation), actually increase the risk of adverse events.

The wealth of blame and accountability technology directed at public psychiatrists suggests the existence of state strategy to direct the burden of this additional risk, caused by poor resourcing and the failings of the risk-focussed usual care system, to public psychiatrists. Psychiatrists spoke in terms of ‘bearing’, ‘tolerating’ or ‘carrying’ sometimes great risk, for the sake of their patients, and even ‘on behalf of the community’, without any sense of ‘backing’ from their risk-averse employer, the state.

Responsibility without control
The second paradox of contemporary public psychiatric practice is related to the first in the involvement of the responsibilisation and blame expressions of influence. Mental health legislation ‘responsibilises’ psychiatrists for involuntary treatment and detention, and for clinical decisions such as admission and discharge. But because of resource restrictions and de-professionalisation practices, psychiatrists are hampered in the effective exercise of their professional discretion. Under current legal and clinical arrangements, psychiatrists are held legally and personally responsible for decisions they don’t make and cannot feasibly control.

The implications of these findings are clear. In the exercise of strong, unbalanced and irreconcilable governmental pressures against public psychiatrists, public mental health services are ‘killing their golden goose’. State mental health services desperately need the professional expertise, care, cooperation and good mental health of public psychiatrists. Rather than valuing and cultivating this professional capital, the current arrangement of power relations devalues and exploits it.
The deployment of mental health law within the assemblages of power relations
From the wealth of empirical evidence of strategy employed by the state to exert influence upon employed psychiatrists, two powerful objectives of the state were suggested: to minimise expenditure, and to avoid electoral criticism. In terms of the wealth of strategy generated by them, these two additional objectives appeared to significantly ‘trump’ the saliency of the expressed policy rationalities, and, particularly, of the rationalities of rights and facilitation of access to treatment. This is a significant finding of the Phase III sub-study, in the tradition of Dean’s ‘inconvenient facts’ phenomenon. The study findings suggest that the state’s mental health policy is driven, primarily, by concern to provide the least-costly level of service that is electorally acceptable, whilst at the same time seeking to minimise perception of its shortcomings.

The governmental analytic suggested that strategies for the achievement of these objectives and rationalities were operationalised by the state into a number of vectors of influence directed at public psychiatrists, as set out in Figure 10. These expressions were conveyed to psychiatrists through a number of technologies of power, including, and prominently, mental health law. These results confirm views, developed on other bases, that although risk-based mental health law ostensibly regulates the behaviour of particular consumers of mental health services, its principal effect is to regulate the practice of public psychiatrists (Aviram, 1990; Szmukler, 2011) in the interests of the state.

Effects of the deployment of mental health law on access to services
The study found that mental health law within the Phase III jurisdictions is engaged:

- to enforce informal triage practices, such as gate-keeping and case-making, by the state and by individual clinicians;
- for the medico-legal protection of state and psychiatrists;
- to support blame and accountability mechanisms leveraged against public psychiatrists, and
- to authorise involuntary risk-focussed usual care protocols.

The study showed that each of these forms of engagement, including the provision of ‘treatment as usual’ risk-focussed usual care, has a profoundly negative effect on access to mental health services.
CHAPTER 5: PHASE IV: SYNTHESIS RESULTS & DISCUSSION

Health researchers cannot ignore the responsibility to integrate, even as they grapple with the ethics and politics of integration.

(Thorne et al., 2004, p. 1360)

[There is a] need to recognise the dialectic between governance from above and below.

(Stenson, 2008, p. 45)

Overview

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5.3 Synthesis of findings ............................... 251

As described in sub-section 2.7.3 Synthesis method, Phase IV of the mixed-model study, comprised as a synthesis of the Phase II and III sub-studies, is performed with a view to the principles of meta-narrative review (Greenhalgh et al., 2005), meta-study (B. L. Paterson et al., 2001), and meta-ethnography (Dixon-Woods et al., 2005; Noblit & Hare, 1988). This approach requires actions of synthesis from the perspective of theory, method and findings respectively. A summary of the results at each of these three levels is set out in sections 5.1 Synthesis of theory to 5.3 Synthesis of findings below.
5.1 SYNTHESIS OF THEORY

The meta-study method requires consideration of how the theoretical frameworks employed in the two sub-studies have shaped their data (B. L. Paterson et al., 2001).

‘Riding the wave’ of irreconcilability

The significance of the network governance and realist governmentality theoretical frames in the respective sub-studies is distinct. The network governance approach features characteristics of stakeholders in their roles as nodes in a governance network. The realist governmentality approach features strategies of influence and response between stakeholders.

The respective theoretical approaches have distinct paradigmatic and historical orientations. In Phase II, the characterisation of regulatory capacity and agenda identity was performed through literature, and not specifically located in time nor in space. Proceeding from a post-positivist, network governance theoretical base, Phase II findings took form as a set of interpretations intended to approximate the objective reality of the regulatory capacities and agenda identities of each of the class of domain actors assessed. By contrast, the findings from the governmentality study arrive from application of a post-structuralist genealogical perspective and, thus, are immediately contingent in relation to the conditions under which the data was gathered.

The ultimate integration of such distinct theoretical perspectives is simply not possible. Rather, as suggested by John Braithwaite, the approach to synthesis must be iterative and adaptive:

\[G\]ood surfers are hardly logical positivists. They do not have a fixed theory of waves that they execute by strictly following the sequence of wave-riding protocol. They adapt to the wave—a lot…

It would be possible to be a better surfer with the benefit of randomised control trials … Yet any number of randomised control trials will not change the fact that to be a great surfer we need to probe the wave, feel how it reacts to our body, and be responsive to that reaction. You need experience that only comes from ‘doing’, from learning to recognise and use patterns… Good surfers are neither determinedly deductive theorists of wave-riding not determinedly inductive. They are skilled at shuffling backwards and forwards between deduction and induction.

(J. Braithwaite, Coglianese, et al., 2007, p. 308)
Like Braithwaite’s wave rider, the researcher in synthesis of the Phase II and Phase III sub-studies must iteratively consider practice and discourse generated ‘in the real’ by a stakeholder in the Phase III sub-study, with findings about the capacity and interests of that stakeholder from the Phase II sub-study, and vice versa. No single portrait is possible. But, as in the case of the wave rider, the reader is rewarded for this awkward, pragmatic, iterative effort with a better ‘probe of the wave’—in this case, of the dynamics of the regulatory environment of the mental health law and access domain.

To tell and to appreciate the ‘story’ of the findings of the mixed-model study requires not only suspension of paradigmatic preference, and concern about epistemological disjuncture, but appreciation of the benefits to be realised by an alternatively broad and narrow, normative and non-normative, essentialist and contingent, research gaze.
5.2 SYNTHESIS OF METHOD

It is a further principle of meta-study to consider how the methods employed in the respective sub-studies have shaped their data (B. L. Paterson et al., 2001).

As the Phase III sub-study addressed only expressions of attempted influence directed by or to public psychiatrists, the resulting data appear more densely gathered around the public psychiatrist node than around the other three stakeholders in the domain. This does not reflect any greater centrality or significance of public psychiatrists within the relevant domain, however, but only the restrictions of the method imposed.

More broadly, the Phase III sub-study, with its methodical address to micro-relations, highlights more specific tensions for the domain actors than the more global Phase II sub-study. Thus, though both studies identified psychiatrist despair and some of its common causes (such as the blame phenomenon), only the Phase III sub-study pointed to the powerful and ‘productive’ conflict, experienced by most informant psychiatrists, between the demands of the system on the one hand, and the needs of their patients and a doctorly self-concept on the other.

By contrast, the focus within the Phase II study on the interests, capacity and potential of stakeholders elucidated a powerful frame for interpretation of the findings of practice and discourse arising in the limited though intense scope of the Phase III sub-study.

The methods are complementary in that they each enlarge and corroborate understandings derived in one or the other.
5.3 SYNTHESIS OF FINDINGS

The narrative integration of the principal research findings of both studies took a circular form roughly emulating the governmental flow between assemblages identified in the Phase III sub-study. Focus shifted from the community, to the state, to psychiatrists, and then to consumers, pausing with each for reciprocal translation (viewing the results of each study in the terms of the other) (Dixon-Woods, Cavers, et al., 2006) to form new synthetic constructs.

This sub-section does not replicate the entire process of synthesis but rather identifies the central constructs, per stakeholder, in a narrative context. Results are further distilled in a concluding summary of argument.

The Community

The pre-occupations of this stakeholder emerged as fundamental to the great tangle of expectations, interests and influences arising within power relations across the balance of the domain membership.

The Phase II study represented the community’s interests as alternating between concern for, and fear of, the consumer’s mental ill-health. By contrast, the Phase III sub-study provided almost no data to support the concept of the community’s beneficent concern in the provision of access to mental health services, although this may have resulted from limitations on its scope. It did, however, provide support—albeit gained from the perspective of psychiatrists—for the primacy of objectives in the community to reduce fear and uncertainty, and to be protected from violent consumers.

It is difficult to avoid the suspicion that the Phase II-identified community concern for the provision of mental health services might arise from the fear of the negative consequences of its non-provision, but this conclusion is not necessary, nor particularly supported by Phase III findings. A more justifiable interpretation, arising from synthesis of Phase II and the balance of Phase III findings, which did include positive findings of the strategies of the state, is that the community has both beneficent and safety concerns with the latter having greater salience.

The State

Order of interests

The Phase II study found that provision of access to service figured below community protection in the order of the state’s interests. It also figured below cost-control which
suggests that the state doesn’t rate the electoral power of more investment in access to mental health services particularly highly.

These results corroborate Phase III findings that there are powerful, additional objectives founding the state’s strategies towards psychiatrists: namely, to minimise expenditure, and to minimise public criticism (directed to the state) for violence committed by consumers. Access to service features as an expressed element of the rationale for policy but only subject to these considerably more potent policy drivers.

The Phase III sub-study elucidated how the state strategises to provide access to mental health services, alongside its other powerful policy drivers of cost control and perception management, whilst at the same time seeking, ostensibly, to protect the community from adverse events and also consumers’ human rights. As identified in the Phase II study, this is profoundly ambitious task set—because the state retains such firm involvement in both managing and providing services, because the risk-averse electorate has such ambivalent views about mental health issues, and because the whole must be performed in the context of low budgets and overwhelming demand.

**Role of mental health law**

Despite that cost and public criticism minimisation is not reflected in its rationale, mental health law was found to be a prominent technology for the state’s advancement of, and psychiatrists’ resistance to, these powerfully productive objectives. This occurs both directly—in the state’s use of mental health law technology to transmit influence to public psychiatrists—and indirectly, in psychiatrists’ engagement with mental health law in response to the state’s governmental influences.

**Mental health law and access**

Mental health law is directly engaged by the state to delegate responsibility for involuntary treatment and detention to public psychiatrists, and also as a prime structural and normative vehicle for the ‘prioritise risk’ discourse. Phase II literature revealed a prominent discourse to the effect that risk-focussed usual care, authorised by formal usage of mental health law, has a serious, negative effect on access, as viewed on a population basis. There was considerable data also, in the Phase III sub-study, on the effects of the risk priority in generating practices in public psychiatry that have a negative effect on access to quality services.
The Psychiatrist

*Psychiatrists with push-back*

The Phase III sub-study found that psychiatrists’ responses, though often compliant, were frequently also resistant to state pressures. In their resistant mode, psychiatrists returned responses back to the state in the form of subversive strategies of influence: to protect themselves against blame, and to case-make for selected patients notwithstanding bed availability, the dominant risk discourse, and, indeed, the proper interpretation of mental health law. These results both expand and refine the Phase II portrait of ‘besieged’ psychiatrists with poor regulatory capacity. As predicted in Phase II, however, Phase III found psychiatrists prone to despair in prosecuting a daily battle against the system—against its risk focus, poor resourcing and blame strategies—to pursue practice according to their doctorly values.

*Domination of public psychiatry by state interests*

The poverty of the psychiatrists’ overall regulatory capacity was reflected in the relative strength of state strategy in relation to public psychiatrists through both formal and informal regulatory technologies. The state cannot fully control the perceptions of the electorate, nor the expression of mental ill-health by consumers. But the Phase III sub-study confirmed expectations formed from the Phase II study that the state well and truly ‘governs’ public psychiatrists, converting their preparedness to bear responsibility, and their professional expertise for its own, quite un-doctorly ends. The most important access effects overall identified in the Phase III sub-study—including ‘gate-keeping’, defensive practice and informal triage—were not reflections of the state engaging mental health law itself in support of its own objectives but, rather, the state governing psychiatrists to engage mental health law, both formally and informally, on the state’s behalf.

*Psychiatrist practices engaging mental health law and affecting access*

Findings in the form of elements of the assemblages in the Phase III sub-study disclosed a great deal of interesting data about how psychiatrists rationalise their conflicting pressures overall. The present focus is narrower, however. Table 13 summarises the public psychiatrist practices found in the Phase III sub-study that engage mental health law either in compliant or resistance response to a state-sponsored vector of influence, and which resound in an effect on access, as defined in this thesis.
Table 13
Phase III findings: Public psychiatrist practices engaging mental health law that affect access to mental health services (in response to state influences).

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<thead>
<tr>
<th></th>
<th>Compliant with state influence</th>
<th>Resistant to state influence</th>
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<tbody>
<tr>
<td>Pro-access effect</td>
<td>‘Case-making’</td>
<td></td>
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<tr>
<td>Anti-access effect</td>
<td>Risk-focussed usual care with formal use of mental health law.</td>
<td></td>
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<tr>
<td></td>
<td>‘Gate-keeping’:</td>
<td></td>
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<tr>
<td></td>
<td>o varying risk assessment practice with bed availability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o the flexible interpretation of ‘risk’</td>
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<tr>
<td></td>
<td>o manipulation of the definition of mental illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o high threshold for ‘least restrictive’ treatment.</td>
<td></td>
</tr>
<tr>
<td>Risk-focused treatment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o non-risky not eligible for public mental health care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o damage to the therapeutic relationship</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o substantial opportunity cost</td>
<td></td>
</tr>
<tr>
<td>Blame management by defensive practice.</td>
<td></td>
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</tr>
<tr>
<td>Pro- and anti-access effect</td>
<td>Informal triage practices.</td>
<td></td>
</tr>
</tbody>
</table>

Psychiatrist despair, access and mental health law
Both Phase II and the Phase III studies identified an important additional effect of mental health law on access to mental health—psychiatrist despair—that cannot be correctly featured as a practice per se of public psychiatrists (though it is an action-on-the-self in governmentality terms).

It was identified, however, that imposition of the risk-focussed care system over the public psychiatrist’s preferred mode of practice, and pre-occupation with the possible future scrutiny of their risk assessments, are two major sources of stress and other negative emotions for public psychiatrists. Very significant levels of despairing emotion were
described in the Phase III sub-study. The significant work-related despair of clinicians affects the efficacy of their therapeutic relationships, and the quality of psychiatric care and treatment available.

It is likely, too, that these stresses, related to burn-out and departure from public practice, are critical contributing factors to the chronic, increasing projected shortage of public psychiatrists, the greatest shortage of all the medical specialities in Australia (Australian Medical Association, 2012).

As the fundamental element of legal and normative infrastructure for the provision of risk-focussed usual care within the public system, mental health law stands causally in relation to the generation of psychiatrist despair, and its negative effects on access to mental health services.

**Governance by psychiatrists in the realm of the consumer**
The continuing flow of governmentality was identified, not just in the form of vectors of influence returned by psychiatrists to the state, but also in a process of governmental flow through to psychiatrist-consumer relations.

Much of this flow is entirely consistent with the strategies of the state as enacted within the originating state-psychiatrist dyad. It is within the realm of the therapeutic relationship, in fact, in which access effects seeded ‘earlier’ (in genealogical terms) by the state, actually flower. Thus, psychiatrists’ compliant ‘actions external’ in response to state vectors convert into strategies compliant with state expectations, generating vectors of influence directed at consumers, such as gate-keeping, the provision of risk-based care and defensive practice. Each of these vectors of influence engage mental health law as their operative technology, and each resound negatively in access to service for consumers.

**The ‘good doctor’ interest**
Some of the governmental flow of influence from the state-psychiatrist assemblage to the psychiatrist-consumer assemblage converts, not to any further expression of influence by psychiatrists designed to constrain consumers, but rather, and simply, to care for them.

The Phase II study found psychiatrist objectives in the A2b: Psychiatrist to consumer assemblage that support an additional and powerful ‘good doctor’ agenda identity for many public psychiatrists, a characteristic that did not clarify in the Phase II study.
The Consumer

Consumers leverage their ‘treasure’ to obtain access

The Phase II study portrayed consumers with considerable regulatory capacity—that is, with power to influence other stakeholder’s behaviour—in the form of the expression of their mental illness. They were identified as having a poor capacity overall to make use of this potential by reason of their very low authority, and their lack of connectedness and capacity to organise. In terms of interests, it was found that they would prefer to receive quality services and support that respects their human rights and engages them. In the absence of this, however, it was found that many consumers will accept the type of service that is available, even if it infringes their rights or dignity, or is otherwise inappropriate.

This portrait is confirmed in the Phase III sub-study, albeit from the perspective of psychiatrists, with the consumers’ objectives registering as satisfaction of clinical and social needs, rights to service, and rights to autonomy. Consumers strategise to obtain service by expressing their need in the most influential manner they can manage, indeed by leveraging their ‘treasure’—the expression of their illness. Many have learnt the pivotal importance of risk and seek to demonstrate it in the language or action of this expression. Some have learnt to value-add to the influence of their plain clinical need with the advocacy of third parties or the involvement of the media. Some refuse to comply with treatment. All of these means—these operative technologies, in governmentality terms—increase pressure on psychiatrists to provide at least a level of the desperately needed service.

Psychiatrists’ responses to these pressures are mediated by conflicting pressures from the other assemblages in which they are involved and by their limited regulatory capacity. Thus, psychiatrists’ responses-in-action to consumers’ pressures for treatment, or non-compliance, were found to be effectively delimited by state pressures to provide risk-focussed usual care, to protect scarce resources, and to practice defensively, and also by community pressures to accurately predict adverse events and to not make (apparent) mistakes.
<table>
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<th>Summary of Argument</th>
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**Regulatory capacity is irregularly distributed within the mental health policy domain**, with the state possessing significantly more actualised regulatory capacity than any of three other principal actors (consumers, the community and public psychiatrists).

**Access to service is a priority for all of the stakeholders.** There are latent capacities in the balance of the domain which could be actualised and harnessed for its greater achievement overall—in particular, the expertise and doctorly orientation of most psychiatrists, and the capacity of consumers to take responsibility for treatment. Shifting the balance of the electorate’s concerns from ‘fear’ to ‘care’, also, is possible whilst its ambivalence remains.

Presently, however, the minimisation of costs and of criticism for ‘permitting’ adverse events are much higher-priority concerns for the state. As a lower-priority concern of the actor with the highest regulatory capacity, **access to service currently has less salience in the mental health policy domain than these other interests.**

Mental health law is a key regulatory technology of the state which, in its formal usage, effects a significant intrusion into traditional medical care processes, into the rights of the consumer, and on the expectations and roles of other relevant actors. The principal rationale provided by the state for this level of intervention is that mental health law supports human rights and facilitates access to mental health services.

**There is disjuncture, however, between this rationale and the logic of governmental strategy** that points clearly not to the protection of rights, nor to the facilitation of equitable access to service, but rather to the minimisation of costs and electoral concerns.

**Formal usage of risk-based mental health law de-values the therapeutic relationship between consumers and psychiatrists.** Risk-focussed usual care was found to represent a significant opportunity cost in the provision of more effective traditional care. **It also makes psychiatrists responsible** for the outcomes of the treatment process. Many psychiatrists respond to the requirement to provide risk-focussed usual care, as well as to their responsibilisation for its outcomes, with indications of psychological detriment.
Additionally, there is widespread, informal usage of risk-based mental health law by public psychiatrists for purposes unsanctioned by the legislature but in compliance with state pressures in line with its prime cost and criticism control objectives. These engagements include wide-spread gate-keeping (to keep consumers ‘out’), other forms of informal triage, and defensive practice (in support of the state service).

Psychiatrists were also found to engage mental health law informally in resistance to state vectors of influence. These practices included case-making and certain informal triage practices that promoted consumers’ access to care, and defensive practice (to protect the psychiatrist) which did not. Reflecting the lesser capacity of psychiatrists in the domain, however, these practices remain subsidiary to compliant usages.

The study found that, overall, these practices generated negative effects on access including:

- denial or discontinuance of needed public psychiatric care;
- non-provision of traditional, holistic, individualised, effective psychiatric therapy;
- chronic despair amongst psychiatrist, and
- waste of valuable professional time and expertise in non-therapeutic activity.

In these effects, consumer access to timely, efficient and appropriate care was inhibited. Risk-based mental health law was operative and necessary in all of the practices generating these effects. These effects support the discourse that risk-based mental health law inhibits, rather than facilitates, access to mental health services.
I refer to the ubiquitous call for historically specific, contextually embedded, multi-scalar approaches to policy research.

(Fairbanks II, 2008, p. 36)

The only true voyage of discovery...would be, not to visit strange lands, but to possess other eyes, to behold the universe through the eyes of another, of a hundred others.

(Proust, 1923)

Overview

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Aim of the thesis
The Introduction to this thesis outlined a looming crisis in mental health provisioning, with the current mismatch in demand and supply for access to even basic treatment for mental illness projected only to increase, markedly, and in the near future. Access to timely, appropriate and effective mental health treatment is now, more than ever, central to the policy task in the sector—not just for desperate consumers and their staunch but weary doctors, but for the risk-obsessed community and cost-obsessed governments. For there will be much less safety, and much more illness, if access to service is not improved. There will be massive and increasing cost—all over government, all over society.

There is nascent recognition that continuation of the current design of public mental health service provisioning will result in failure to meet the access challenge (Dutton, 2014; Nous Group, 2014). Mental health law is the key regulatory technology underpinning the service system (McSherry, 2008). If the system is to be reformed successfully—that is, with the effect of reducing the gap between demand and supply for services—the intended and unintended effects of its central regulatory technology on this central policy aim must, at the very least, be understood. Contributing to this aim has been the quest of this work.

In this thesis, I set out to investigate the effect of risk-based mental health law in the light of contradictory arguments that it facilitates, and that it inhibits, access to mental health services

Methodology
To achieve this aim, I designed a mixed-model framework integrating network governance and realist governmentality approaches. There were additional, formal scoping and synthesis phases. The resulting governance+governamentality methodology identifies, gauges and maps the practice and effect of regulatory influence within a defined mental health law and access policy domain. Using this model, the ‘access to mental health service’ policy objective is held in the same investigatory frame with other objectives and interests of stakeholders within the domain.

Paradigmatic challenges
Integration of the post-positivist governance and the post-structuralist governmentality perspectives required resolution of concerns about the epistemological, ontological and
normative disparities between them. This was achieved in the adoption, overall, of an iterative, pragmatic approach, and by care in the order of integration, along with some re-assessment of realist governmentality’s alleged non-normativism and anti-essentialism.

Methods
Phase I of the mixed-model framework hypothesised membership of the mental health law and access policy domain, fixing on four principal stakeholders for investigation—the consumer, the community, the state and public psychiatrists. It also addressed the formulation of the problematisation to be pursued as a foundation for the research. There will be more about this in later sections of this Conclusion.

There were two qualitative sub-studies at the heart of the framework.

The Phase II network governance sub-study employed a modified critical interpretive synthesis method for literature review. The research focus was to characterise and relativise the regulatory capacity and agenda identity of the identified members of the mental health law and access domain, and specifically, to gauge the salience of the access objective overall.

The Phase III realist governmentality sub-study engaged ethnographic methods to conduct a governmentality-inspired analytic on relations of influence between public psychiatrists and the three other members of the domain.

The Phase IV interpretive and integrative synthesis of the two sub-studies followed recognised principles of meta-synthesis, including meta-study, meta-ethnography and meta-narrative review.
6.2 ADVANTAGES AND LIMITATIONS OF THE METHODOLOGY AS APPLIED

I have argued in this thesis that the twinning of the network governance and realist governmentality approaches is reconcilable at the level of theory, and generates useful synergy for the purposes of policy analysis. Advantages continue at the data level, where the twinning generates design advantages of ‘like with like’ (permitting advantages of triangulation including corroboration and enlargement), and complementary ‘unlikes’ (where the inadequacies of one method are compensated for in the other).

In addition to the considerable restrictions on research scope made necessary by the resource constraints of this PhD candidature, there were certain limitations in the methodology of the mixed-model study that became apparent in its application. These arose both from unforeseen elements of the research context and from more intrinsic limitations of the respective approaches.

The practical advantages and limitations of the mixed-model methodology, at the level of data, are described in this sub-section.

6.2.1 ‘LIKE WITH LIKE’ ADVANTAGES

Parallels between particular investigatory elements in the two sub-studies facilitated both corroboration and enlargement of the respective outputs.

For example, the characterisation of a stakeholder’s interests and culture within the Phase II methodology is analogous, though not identical, with that actor’s ‘objectives’ and ‘rationalities’ in the structure of the Phase III analytic. Both are inductive results, though the Phase II characterisation arises as a product of the critical interpretation of literature, while the Phase III results are inferred from localised evidence of practices of influence.

The Phase II sub-study identified the state’s high-priority interests in both cost control and attention to electoral concerns, a result directly corroborated in Phase III. But the Phase III approach was able, further, to enlarge on this portrait (at least so far as the Phase III jurisdictions are concerned), pointing to an interpretation of the community’s concern with mental health issues as being principally about ameliorating or preventing anti-social expressions of mental ill-health, rather than particular concern for access, quality care
or positive expressions of mental health.

Similarly, the ‘actions-on-the-self’ of psychiatrists in the Phase III sub-study reflected, although in more detail, and with greater texture, the despair and problematic professional identity of psychiatrists, as identified in Phase II. By the same relationship, the strength of vectors of influence by psychiatrists on consumers, and resistant ‘actions-in-response’ reciprocated to the state, as found in Phase III, reflected, and yet further particularised, the regulatory capacity of the psychiatrist as estimated in Phase II. Although a determination to preserve a level of clinical autonomy was identified in Phase II, the actively subversive, resistant subject psychiatrist really only emerged in Phase III.

It is conceivable that integrating the different approaches might give rise to incommensurable sets of data. That this did not occur in the mixed-model study supports the credibility of the integration. Rather, the Phase II results tended to function as a set of hypotheses about the dynamics of the mental health law and access domain to be further tested and particularised in Phase III.

### 6.2.2 COMPLEMENTARY ‘UNLIKES’

The disparity of method—that is, the ‘unlikes’ within the mixed-model framework—enabled weaknesses or empirical gaps in each study to be addressed in the other.

Again engaging the metaphor of Phase II hypothesising for Phase III, Phase II characterised a profile of each actor’s regulatory capacity, yet it didn’t explain how capacity to influence is exercised, or its effect by, or on, real people.

By contrast, Phase III avoids totalisation and reflects the ‘how’ of that exercise in space and in time. It is precisely the localised context, however, that would ordinarily discourage generalisation of the results from a governmentality study, if those results weren’t corroborating interpretations suggested in a more broadly-based study. It is a particular strength of the mixed-model approach that globalised concepts can be tested in a located context, and located results confirmed in a more generalised paradigm.

The particularising edge, it should be noted, does not always fall on the side of the Phase III methodology. There are elements of analysis beyond the contribution of the realist governmentality snapshot, and not only by reason of the limitations of locatedness. For example, Phase III data demonstrated the results of mismatched regulatory capacity...
between, say, the state and psychiatrists, and crucially, the success of the state’s strategies of influence as played out at the coal-face. Other than suggesting the impact of alternative competing rationalities and objectives, however, Phase III methodology cannot explain why the strategies ‘work’ or ‘don’t work’. In the depth of the analysis of the elements of regulatory capacity, and with more normative latitude, the Phase II analysis could provoke valuable theorising on why efforts to govern are or are not successful.

6.2.3 LIMITATIONS OF THE METHOD

There were some unexpected effects on data arising from the application of the mixed-model method, and areas in which application of the respective methods might have been improved.

Actual v. potential regulatory capacity
Firstly, it was unforeseen in the design of the Phase II method that interpretations of the literature in relation to regulatory capacity would require, or at least strongly suggest, an interpretation of both actual and potential regulatory capacity. But it became apparent in Phase II that the distinction is an important one for analysis of alternatives and subsequent policy practice. Analysis may have been better served by a priori consideration of how the valuable element of potential regulatory capacity might be identified and interpreted.

Exposures in application of Phase II methodology
Although application of within-study design strategies in the Phase II sub-study attempted to ameliorate the disadvantages of ‘solo researcher syndrome’ in an interpretive study, these were not able to match the benefits of a larger project team, author survey or other form of peer review. This is not to suggest that the results of the Phase II are not ‘correct’ or valuable, but only that their confirmability is not strong. There is added advantage then in the placement of the Phase II sub-study within the mixed-model methodology for the additional rigour lent by the data triangulation referred to above.

Inability to relate the subject’s actions-on-the-self to specific vectors
A surprise element in the application of the Phase III method was that it was not anticipated that ‘actions-on-the-self’ reported by psychiatrists could not be reliably inferred to relate to one or other of the influences being visited upon them. It was not even possible to relate specific actions-on-the-self to effects within any particular dyad. The composition of the
subject is an important analytic concern in realist governmentality, and its treatment, empirically, in Phase III may have benefitted from additional design provision.

Too much data?
The research focus required production, in Phase III, of data detailing stakeholders’ engagement with mental health law, and the effects of those engagements on access to treatment. A great deal more data was gathered in Phase III, however, relating to strategies of influence and response that did not engage the technology of mental health law. Whilst it was highly instructive—indeed, constructive in terms of the genealogical approach—to see the technology of the mental health law in the same investigative frame as other lines of influence, the sifting for results particular to the research question entailed considerable analytic load.

Limitations on the application of the Phase III methodology
Ideally, the Phase III sub-study would have involved ethnographic data and discourse analysis supporting the derivation of a genealogy in each of the twelve potential sub-assemblages as between the four principal stakeholders (or, possibly, an even wider group). As has been noted, however, for practical reasons the Phase III methodology was exposed only to the six dyads within the overall group that included public psychiatrists. Data gathered related most particularly to relations in Assemblage A1 (The State and Psychiatrists), with somewhat less to those in Assemblage A2 (Consumers and Psychiatrists). There was little research product arising in relation to the dyad of relations at Assemblage A3 (Community and Psychiatrists).

Thus, and although the negative effects were ameliorated by its presence within a mixed-model study, the Phase III sub-study is highly contextual. The stand-alone results of Phase III, and to the extent that they influence the synthesis, of the mixed-model study, are results contextual to Australia only, to the relevant five jurisdictions of mental health law and mental health systems only, to the timing of the sub-study (with fieldwork conducted in 2013 and 2014), and, largely also, to the 28 individual clinicians as interviewed by me.

Conclusion
This sub-section has revealed some shortfalls and ‘surprises’ in the application of the methodology, and some areas for improvement. It is argued, however, that the effect on results overall of these concerns, as well as of the known ‘exposures’ of the respective methods, were mitigated considerably by the triangulation advantages of the integrated framework.
6.3 SUMMARY OF FINDINGS

In this sub-section. I digest the principal and additional findings of the mixed-model study subject to the limitations discussed in previous section. For a longer ‘summary of argument’, I refer to section 5.3 Synthesis of findings in Chapter 5: Phase IV: Synthesis.

6.3.1 PRINCIPAL FINDINGS

The study identified the state as a stakeholder with overwhelming, actualised regulatory capacity within the mental health law and access policy domain. By contrast, the actualised capacity of the consumer, community and public psychiatrists to influence outcomes within the domain was relatively low.

Representing only a third-order interest of the most influential stakeholder, the state, ‘access to service’ was not rated as a particularly salient, operative interest in the domain overall.

The study found that that the state largely successfully influences a relatively uninfluential stakeholder, public psychiatrists, to act against its own professional and personal interests in support of the state’s highest priority interests—cost control and the minimisation of electoral criticism.

The study also found that the state’s strategies of influence to progress these objectives included the use of mental health law to authorise a range of practices that underpin a risk-based service norm in Australian public mental health services. These practices include the use of mental health law:

- to authorise provision of risk management services passed-off as best practice psychiatric care and treatment;
- to manage bed-flow, and specifically to exclude patients from, or discontinue their access to, treatment;
- in other informal triage practices;
- as a medico-legal defensive tool for both state services and individual psychiatrists, and
as an accountability benchmark for the discipline of public psychiatrists.

The effects of this formal and informal use of mental health law included:

- that public, psychiatric treatment for clear psychiatric need was denied or discontinued, despite the non-availability of alternative service paths;
- that access to treatment was provided and denied on the basis of criteria other than clinical need or legal eligibility;
- that the use of traditional, holistic, innovative and individually appropriate modes of psychiatric treatment and care was inhibited;
- profound negative effect on the mental health of public psychiatrists, and
- an outstanding incidence of waste of valuable clinical resources in the diversion of professional psychiatric expertise to non-therapeutic activities.

These phenomena were found to inhibit equitable, and legally and medically justifiable, consumer access to timely, appropriate and effective treatment. Thus, the study found that the practice of risk-based mental health law inhibits access to mental health services.

6.3.2 ADDITIONAL FINDINGS

The relationship between mental health law and the service system

The study found that mental health law mobilises risk, and that risk mobilises mental health service. Thus, the study supports the contention that risk-based mental health law is a central structural pinion of the mental health service system (Churchill et al., 2007; McSherry, 2008; Unsworth, 1987).

The informal use of mental health law

The study highlighted instances of informal engagement with mental health law in psychiatrists’ compliant and resistant responses to state influence. Forms of informal engagement found included the creative adaptation of the risk criteria and legislative definitions to screen-out (gate-keep), and to screen-in (case-make), individual consumers.

These findings of informal practice are a valuable insight into the intricacy of regulatory policy implementation, and might be regarded as a particular advantage of a governmentality-inspired investigation.
‘Inconvenient facts’
Querying on the consonance between the state’s rationalities and its real agenda is at the core of the critical nature of the process described in the mixed-model methodology.

In the present study, the found effects of mental health law on access directly contradict the state’s rationale for the mental health law intervention, as explicitly represented within the law and in other policy statements.

Psychiatrist resistance
Arising from its strong focus not only on the expression of influence but also on the responses to it, the study identified a strong vein of resistant, if not outright subversive practice, on the part of many public psychiatrists.

The study showed that the state is, overall, quite successful in organising the professional will, expertise and authority of psychiatrists for its own ends. But it may have overestimated public psychiatrists’ capacity to bear blame and responsibility for outcomes they cannot control, and also their preparedness to ‘de-doctor’ themselves. It may have underestimated the total cost of its emasculation of their professional status and expertise.

Conclusion
In the Introduction to this thesis, I referred to two conflicting policy discourses relating risk-based mental health law and access: the first, that risk-based mental health law facilitates access to care, and the second, that it inhibits access to care. The first discourse relies on an overarching rationality that conflates care and control. If risk-focussed usual care and control is the same as medically appropriate psychiatric care, then risk-based mental health law does support access.

But the mixed-model study does not support this equation. Rather it has shown that risk-based mental health law is used both formally—and, very significantly, informally—to stifle innovation, to limit the range of care practices, in some cases to promote iatrogenic care practices, to lessen the quality of psychiatric practice overall, to restrict the number of patients able to access it, and it has de-medicalised and demoralised psychiatrists to their personal and professional detriment. The results of this study support the discourse that risk-based mental health law inhibits access to service.
6.4 IMPLICATIONS FOR LITERATURE AND PRACTICE

6.4.1 MENTAL HEALTH LAW LITERATURE

The findings of this thesis study contribute to a number of lines of literature within the diffuse mental health law field. It contributes new practical insights about the way risk-based mental health law ‘works’ in practice, to studies emanating, in Australia particularly, from thinkers such as Terry Carney, Bernadette McSherry and Ian Freckelton, who have addressed the place and effect of mental health law within the mental health service system.

Further, and although this is not a rights-based thesis, the study’s finding, overall, that risk-based mental health law inhibits access to service, supports the therapeutic jurisprudence literature that argues for better structural support for the ‘positive right’ to mental health service.

The work also contributes to growing body of literature on the damage caused by the risk focus within psychiatric practice, as championed, in Australia, by Matthew Large and Christopher Ryan and colleagues, Alex Holmes and Lisa Brophy, and, overseas, by many reform-oriented writers, including George Szmukler, Rowena Dawson, Joan Langan, Heathcote Wales, Virginia Aldige-Hiday, Nikolas Rose and Peter Castells.

6.4.2 POLICY LITERATURE

The development and application of a methodology that successfully integrates governmentality theory and practice within a network governance framework is a significant and novel exploit relevant in a number of policy-related disciplines. These include the particularly Australian stream of pluralist regulatory governance thought in which Valerie and John Braithwaite, Scott Burris, Neil Gunningham, Peter Drahos, Colin Scott and Christine Parker feature prominently.

To this literature, this thesis also contributes empirical application of pluralist governance theory—a still-rare undertaking, especially as applied in a social policy domain.

The thesis’ use of the Scott’s NATO heuristic for assessment of regulatory capacity
augmented by the original ‘agenda identity’ (AI) conceptualisation within a practical investigation is also a feature. There is likely fresh recognition, also, in the recognition of a difference between ‘potential’ and ‘actualised’ regulatory capacity.

The work also has strong relevance for the practice of policy analysis, particularly in that stream exploring the practical potential of governmentality analytics represented by Catherine Marston and Greg McDonald, Kim McKee, Randy Lippert and Kevin Stenson, and John Clarke among others. To this literature, the thesis contributes a relatively structured approach to the derivation of a realist governmentality assemblage. In this process, the thesis employs the additional, original sub-element of governmental strategy, the ‘vector of influence’. The notion of ‘governmental flow’ was also characterised.

The mixed-model methodology, and the use of the particular network governance and governmentality ‘tools’ demonstrated in this thesis, has potential to facilitate the effective interrogation of ecologies of power relations within other complex social domains, towards more insightful policy analysis by state and other stakeholder agencies.
6.5 POLICY IMPLICATIONS

6.5.1 FROM THE PERSPECTIVE OF THE RESEARCHER

As identified in section 2.4.1 The problematisation, my personal problematisation of mental health law and access, which motivated this thesis, was relatively non-normative:

‘Access to treatment and care for people with serious mental illness is a major and increasing problem in Australian society. Risk-based mental health law is posited by the state as a fundamental strategy that facilitates access. Is this true? If not, what does it do?’

To move beyond the essentially diagnostic conclusion of this thesis (that risk-based mental health law inhibits access to mental health service) to an action-oriented agenda, requires clarity about the norms attending this further querying. I refer again to the profile of my own interests, also identified at section 2.4 Phase I Scoping methodology, which includes ‘concern for better care and treatment of people with mental health conditions now and into the future… interests in rationalities in law, regulatory governance, therapeutic jurisprudence, and social justice generally’.

From my own perspective, then, I find implications of the instant research findings resounding in human rights, therapeutic jurisprudence and regulatory governance.

First, I consider that, in the balance of the findings, justification evaporates for the considerable interference in intrinsic human rights that mental health law represents. Mental health legislation inarguably infringes rights to bodily integrity and personal liberty as set out in the International Covenant on Civil and Political Rights (ICCPR). But it is recognised, and I acknowledge, that limitations on those rights may be necessary in the context of mental illness (Freeman & Pathare, 2005). The nature of a justifiable restriction is reflected in the principle of proportionality which requires that legislation that restricts ICCPR rights must be ‘strictly necessary’ to achieve public health or health policy objectives (United Nations Commission on Human Rights, 1984). The stated objectives of mental health law feature facilitation of access to mental health treatment. If mental health law does not achieve this objective, the state’s principal justification for the outstandingly intrusive measures constituted by involuntary treatment and detention does not exist.

A law that does not do what it is set-up to do is at best aspirational and harmless.
But a law that provides for involuntary and preventive detention, and for the involuntary administration of chemical and physical therapies with serious effects and side-effects is at best, in its own terms, merely harmful. At worst, if law restricting individual rights to such an extent can be shown to be used for undeclared, unrelated purposes of the state, it may, additionally to its anti-therapeutic effects, represent a dangerous instrument of propaganda or an act of totalitarianism (Arendt, 1973).

From a governance perspective, this argument transmogrifies into the considerably less (though not non-) normative position that, according to the mixed-model study, mental health law simply does not ‘work’. Under its auspice, the mental health services system wastes valuable public resources in defensive and non-therapeutic practice. With the risk focus in place, optimal individual treatment, such as even the available funds might support, is simply not provided. Adverse events are not reduced, and arguably their incidence is exacerbated in some cases by iatrogenic, risk-focused practices. Psychiatric expertise dribbles disconsolately away from the public system. Access to service is gate-kept not facilitated. Social and economic costs continue to mount. Demand accelerates. The central and growing problem of mental illness in the Australian community grows worse in the care of public mental health service system built around this utterly dominating and yet non-performing regulatory technology.

In the context of its current difficulties—the combination of likely continuing scarce resources, significantly increasing demand for services and escalating community concerns—in the near-to medium-term future, the mental health sector is a likely candidate for significant regulatory and service re-structuring, and indeed these processes have already been presaged (Dutton, 2014; Hasham, 2015; Nous Group, 2014). The role and content of risk-based mental health law should be revised in the context of this re-structure. Better still, a fresh scheme of regulation appropriate for the contemporary strengths and needs of the sector—with the problem of facilitating access genuinely to the fore—could be crafted.

Additional discussion in relation to an alternative regulatory scheme, appears in Appendix D to this thesis.
6.5.2 FROM THE PERSPECTIVE OF THE STATE

But I am not a policy-maker. The instant research findings are applicable, and really have practical implications only, for active stakeholders in a position to alter their strategy within the mental health law and access domain. Thus, it is valuable, also, to consider the implications of the research from the perspective of the stakeholder found to possess the greatest regulatory capacity in the domain, the state.

It was suggested that the principal interests of the state in the mental health domain are to minimise cost and electoral criticism. Access to publicly funded mental health service, and protection of the rights of consumers, are also objects, but facilitated subject to the dominant cost concern and perceptions about public safety. These interests rationally suggest a revised problematisation (for the state) of mental health law and access framed as follows:

*How to improve access to mental health treatment for the lowest net whole-of-system cost?*

This broad form of problematisation, formulated with a view to the definition of access set up for this thesis, addresses each of the cost, electoral, public safety and access objectives. Arguably, though, and especially with a view to the difficulties of calibrating access as described in the Introduction, it is both ‘too hard’ and politically dangerous.

A less ambitious problematisation:

*How to provide public mental health service such that the public feels sufficiently safe and is otherwise reasonably satisfied with provisions for access, for the lowest possible cost?*

This alternative formulation is likely precisely the problematisation currently pursued by the state in Australian and other mental health jurisdictions around the world. As has been firmly noted, however, the results of the mixed-model study suggest that the strategies currently adopted for its resolution are ‘not working’. Demand, cost, illness and the incidence of adverse events continue to inflate. Public confidence and the system’s ‘capital’ of psychiatric expertise continue to deflate. It remains to assess what regulatory strategies of the state would ‘work’ better than the current schema to support the resolution of this problematisation.

Though detailed attention to this project supervenes the research focus of this thesis, brief observations about possible directions for state policy reform, as suggested by the findings of the mixed-model study, are set out in Appendix D.
6.6 FINAL WORDS

In the work of this thesis I have come to recognise the delicacy of the notion of ‘regulation’. Regulation is often referenced by such emblems as the very indelicate ‘sticks’ and ‘carrots’, the disparaging ‘nanny state’, or the tricky and normatively-suspect ‘nudging’. Reflecting its origins, the object of regulation is often economic. And yet, defined as ‘intentional action to shape the flow of events’, discipline within a family, teenage cyber-bullying, and almost all law and policy made by the state, can be seen as forms of regulation. Study of the agency of those who seek to influence, and the intended and unintended effects of their actions, are proper, interesting and, indeed, vital subjects for regulatory research (Parker et al., 2004). Policy analysis methodology that can sift sensitively within the morass of human behaviour for large and the small patterns in the traces of power—even within complex and relatively amorphous social policy domains—possesses considerable potential for cheaper, less intrusive and more responsive government.

We understand the health of the tree better if we see it in the wood. We understand the health of the wood better if we examine the trees. Almost all of our human problem domains are, like the mental health sector, multi-stakeholder, multi-objective and multi-modal. Yet we mostly find ourselves fixated on just the one story—either of one of us, a few of us, or a vast group of us. In no single such story can we learn what we need to move past policy dysfunction.

This thesis demonstrates the importance for policy-making of multiple perspectives, and appreciation of the essential freedom and potential power of those who are sought to be governed. It also emphasises the importance of a reflexive approach—even by the state. Aspirational objectives and chimeric rationale are unhelpful rhetoric that blinds effective regulation and policy-making. This thesis suggests that, even in conditions of austerity, the mental health sector as a whole has sufficient broad-based capacity and confluence of true objectives to build more cooperative, progressive, honest, courageous and ultimately more effective policy.
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Appendix A: Phase III interview stimuli

Excerpt 1
From Alisa Lincoln article – ‘Social control and the ‘undeserving sick” Sociology of Health & Illness Vol. 28 No. 1 2006, pp. 54–75 at p 64:

[Staff meetings were dominated by discussions of how to get people into the hospital and physicians were frustrated by their inability to provide needed services.

‘Generally, we no longer worry about who we falsely imprison, we worry more about people getting in or getting kicked out once they get in’ (Dr. M).

Excerpt 2

In a world of limited resources....mental health providers must practice triage, both as to which patients to take on and as to the extent of services provided each patient...The question then is whether judicial involvement...will improve triage decision-making. To even begin to answer that question, one must determine what constitutes optimal triage...

Is it a process that creates the optimal reduction in the costs of crime and involuntary hospitalisation?

Is it a process that provides the greatest response to persons who affirmatively choose the treatment and services available?

Is it a process that provides at least minimal, even if sub-optimal, treatment to the greatest number of sufferers?

What is the goal?
We agree with the observations of Mossman about the negative consequences of risk assessment for the way that clinicians view their patients, and believe that proper consideration of the patient’s situation, symptoms, strengths, and disabilities will be better for patients than attempting to predict their future conduct.

Moreover, risk assessment and categorization have tangible opportunity costs—in particular, the time taken by highly trained specialists to undertake risk assessment, which is time better spent on other aspects of treatment such as building rapport, managing substance abuse, encouraging adherence to medication, and checking on any arrangements that have been made for discharge or for the transfer of the patient’s care.
Appendix B: Other assemblages

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App B.2 Assemblage A3: Community and psychiatrists... 305

This Appendix B describes Phase III sub-study findings that are not relevant to the principal
research questions of this thesis in relation to two sets of assemblages: in A2b: Consumers
to Psychiatrists, and the A3 assemblages involving psychiatrists and the community.

As noted previously, the restrictions on the scope of the Phase III sub-study did not
permit the gathering of subject responses of the state, consumers and the community. Thus,
governmental analytics in this Appendix relating to these assemblage—which involve
subjects other than psychiatrists—are incomplete.25

25 See footnote 22 infra.
APP B.1 ASSEMBLAGE A2B: CONSUMERS TO PSYCHIATRISTS

Findings of the Phase III sub-study in relation to Assemblage A2b: Consumers to Psychiatrists are summarised in Figure B1.

APP C.1.1 THE VECTOR OF NEED

The principal vector of influence projected by consumers to public psychiatrists within the A2b assemblage, experienced with overwhelming force by almost all of the psychiatrist informants, is ‘need’. The study found considerable variation in psychiatrists’ responses to expressions of social need. Homeless patients, for example, were referred to both as ‘bed-blockers’ and ‘poor old things at risk of self-neglect’. But the pool of need, overall, for public mental health services was described as “oceanic” with the services capable of responding to “only the tip of the ice-berg”. Several informants noted and lamented the lack of capacity to provide ‘true asylum’ for sufferers of chronic mental illness or those otherwise unable to care for themselves. On the whole, informant psychiatrists felt keenly aware of, and under pressure to respond positively to, the social and clinical need of patients.

APP B.1.2 CONSUMERS’ STRATEGIES FOR ‘ACHIEVING’ TREATMENT

Psychiatrists perceived that many consumers are only too aware of the necessity to compete for access to scarce mental health resources. Psychiatrist informants spoke of the strategies employed by consumers to leverage their call on access to services. These included practices designed to increase the service’s perception of their riskiness, with reports of threatened suicide, sometimes as coached by clinicians themselves, and the commission of acts of civil disturbance to prompt police attention. They also included the use of third party advocates to assist in the project of admission at the gateway to the service. Advocates might be articulate or powerful relatives and friends, or the police.
The genealogy of Assemblage A2b: Consumers to Psychiatrists
Psychiatrist responses to consumer and third party pressures differed considerably and psychiatrists themselves acknowledged this. The variance centred on individual psychiatrists’ capacity to ‘tolerate risk’ (of the consequences of adverse events), with wide variation in preparedness to engage in defensive practices, including conservative risk assessments, and in engagement of involuntary mental health law provisions.

Overall, however, no responses by psychiatrists additional to the actions-in-response identified in the A1a assemblage were identified in the A2b assemblage. The classification of actions-on-the-self remained the same, with informants positioned in response to consumer pressures from ‘acceptance’ through to ‘negative despair’ as in A1a. Actions externally also included many of the response practices identified in A1a, albeit classified differently as compliant and resistant in accordance with the different content of the relevant vectors of influence.
The Phase III sub-study had few findings in relation to Assemblage A3a: The Community to Psychiatrists, and none of note in relation to Assemblage A3b: Psychiatrists to the Community.

A summary of findings in relation to Assemblage A3a is set out at Figure B2.

A heavy burden from the community in discourse
Blame, again, featured prominently, amongst the vectors of influence psychiatrists received from the community. Psychiatrists recognise community support for accountability technologies levied against them, one likening these to “putting [psychiatrists] in the city square and throwing bad tomatoes at them” [Male, 40-54].

The discourses featured as vectors of influence in Assemblage A3a differed notably from those identified in A1 and A2. These included discourses that: ‘suicide is avoidable’; ‘risk is predictable’; that psychiatrists should ‘make no mistakes’; that psychiatrists are responsible to ‘fix’ mental illness, and to ‘prevent bad things happening’, and, overall, for the ‘bad’ acts of their patients.
The genealogy of Assemblage A3a: The Community to Psychiatrist

Figure B2

The genealogy of Assemblage A3a: The Community to Psychiatrist
Appendix C: Non-legal technologies of influence

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This Appendix C contains data and findings arising from the Phase III sub-study in relation to operative technologies of influence in Assemblage A1a: State to Psychiatrists other than technologies of the common law and mental health law. Data in relation to these two legal technologies, leading to findings specifically related to the principal research questions, are described at sub-section 4.2.1 Technologies of power: The law of the thesis.
Vectors of influence in the form of discourse and practice

The Phase III sub-study found that the technology of employment is engaged by the state to stimulate compliant participation by psychiatrists in a number of discourses of importance to the state.

As described in Figure C1, these discourses include one to manage scarce resources, another to prioritise care to high-risk patients, and a third to align, normatively, with the state service and to minimise perceptions, externally, of its limitations.

The employment relationship also was found to convey a vector of influence in the form
of practice including: protocols within the employment relationship between the state and public psychiatrists for the exercise of statutory powers under mental health legislation, and also a set of practices that significantly de-professionalise public psychiatrists.

APP C.1.1 ‘PRIORITISE HIGH-RISK’ DISCOURSE

Please refer to sub-section 4.2.1.1 ‘Prioritise risk’ discourse of the thesis.

APP C.1.2 RESPONSIBILITY FOR COMPULSORY TREATMENT AND DETENTION

Under each of the Phase III jurisdictions’ mental health laws, psychiatrists acquire either direct or delegated statutory powers to compulsorily assess, treat and detain consumers through their employment relationship with the state. Whether these powers might amount to statutory duties in the context of the mental health legislation of the respective Australian jurisdictions remains, largely, an open question: see para. 12 Hunter and New England Local Health District v McKenna (2014) and Rangarajan & McSherry (2009). For further discussion, please refer to sub-section 4.2.1.2 Responsibility for compulsory treatment infra.

APP C.1.3 ‘MANAGE SCARCE RESOURCES’ DISCOURSE

The study identified a discourse within mental health services, promoted by management and conveyed to staff through various internal processes, to the effect that human and bed-based service resources are absolutely limited, and that the proper means of management of the high demand for services in this scarce resource environment is to limit admissions and promote discharge of patients, such that demand for services equals supply.

Every hospital runs at 100 per cent occupancy. Everybody moves into a warm bed.

[Male, 40-55]

The state of 100 per cent bed occupancy was referred to by several participants as
'bedlock’, with the concomitant implication that ‘flow’ in and out of the system has ground to a halt. By contrast, however, the bed management systems employed in mental health services in the Phase III jurisdictions appeared to ensure that ‘flow’ always continues, even if this means that needy people are not admitted or may be discharged ‘too early’. This is essentially a description of the ‘revolving door’ phenomenon identified in the literature (e.g. Carney, 2010):

... if we went and rounded up everyone who ...would benefit from being an inpatient, obviously the beds would be overflowing. [But instead] I think a sort of a rolling process occurs and people slip off one end and get picked up later ....

[Male, 40-55]

The study confirmed that two central principles in the prevailing system of bed management: admission only where bed availability allowed, and discharge at the earliest possible time. There is a systemic fulcrum in bed management on this basis, albeit one that results in conflicting pressures on psychiatrists:

I reckon I’ve been doing things right if on the same day I’m being yelled at by the crisis team about someone being discharged too early and by managers about non-discharge.

[Male, 40-55]

Bed availability was identified as a significant factor affecting the decision to admit in all but one of the Phase III jurisdictions:

[It’s a question of who is] relatively safe...you need a bed for the person who is a greater priority.  I definitely make decisions on the basis of availability [emphasis original].

[Male, 25-40]

[The decision to admit is] affected by bed availability.  That’s a problem no matter where we go.  It’s ultimately about bed availability.  So you might say that somebody does need to be admitted involuntarily but it may not happen because there’s nowhere for them to go.

[Female, 40-55]

Informants also confirmed pressure to discharge:

I frequently have to report that ‘I have concerns about this patient being discharged at this stage’. But the pressure is such that we’ve got no choice... The pressure is there at every stage to get someone out of hospital.  And then to get someone out of follow-up.

[Male, 25-40]
I’m aware of a lot of pressure to discharge people... you know, to get the throughput going and keep it on at every level... It’s to do with having a bed and pressure to find room for other people to come in

[Male, 40-55]

There were a number of reports of discomfort for psychiatrists caused by this twin set of ‘pressures’—to admit and to discharge on the basis of bed availability. One informant sought official recognition:

Informant: I asked for some kind of written acknowledgement of the issues we were facing.

Interviewer: Who did you ask for that?

Informant: I asked the direct line management, the powers that be...

Interviewer: What were you specifically asking for?

Informant: Just an acknowledgement of severe bed pressures, how these directly affect decisions to discharge, probably decisions to admit as well.

[Female, 40-55]

She was unsuccessful.

There appeared to be considerable variation across jurisdictions and between services as to the allocation of responsibility for bed management in practice. Some services engage external bed managers. Other services have designated bed management employees, often nurses with clinical experience. In yet other services, managing psychiatrists ‘guarded’ retention of their current bed-management responsibilities.

Notwithstanding that the day-to-day administration of bed management might be organised under the role of a body or employee other than the consultant psychiatrist, it was found that a consultant is required to ‘sign-off’ on admissions and discharges, and always does so in relation to admissions and discharges of patients subject to involuntary mental health orders. These professionals are made aware of their duties through the prevailing discourse of ‘proper’ flow management:

Well what a bizarre world it would be if that was not the case [that pressure is exerted on physicians to use their available resources effectively]? Would you actually want to have senior technicians using their resources ineffectively or inefficiently?

[Male, 40-55]
Yeah but I mean like if you’re running, like I have, small teams, I spend a lot of energy trying to get them to say what can we deal with and what should we not be dealing with.

[Male, 55+]

Much of this discourse, transmitted in the course of the employment relationship, is oral (‘being yelled at by bed managers’, ‘trying to get them to say…’)—towards enforcing prevailing workplace protocols. There may be written in-house ‘resource management’ memoranda, guidelines or the like that also reflect the flow management discourse, but as the cooperation of services was not sought for the Phase III sub-study, such documentation, if it exists, was not available to the study.

There is an associated line of written discourse, however, in the form of triage guidelines prepared specifically for mental health patients. Triage guidelines for three of the five Phase III jurisdictions, as well as the mental health triage tool from the Australian Triage Scale published by the Commonwealth Government (Department of Health, 2013), were obtained and analysed in the course of the study.

The triage process is recognised as a method of regulating the flow of patient demand according to need (Grigg et al., 2007). With this understanding, coupled with the clear result from the study that bed availability is a major influence on clinical decision-making about admissions and discharge, it surprising that only one set of triage guidelines addressed resource availability as a possible influence on decision-making:

> It is understandable that triage decisions are influenced by a patient’s needs relative to those who require access to the service at a given time. However, mental health services are strongly encouraged to promote consistency in triage decision-making. … To minimise the extent to which fluctuations in ‘supply’ have a bearing on triage decisions, triage clinicians are urged to make decisions (and triage scale ratings) based on their assessment of clients’ need, risk and urgency, rather than staff availability at the time of contact. The mental health services’ capacity, or lack of it, to provide responses consistent with triage determinations is an important indicator of how the service is coping with its day-to-day demands [emphasis added].

(Department of Health, 2010, p. 22)

In this case, Victoria’s written triage guidelines contradict the twin-pressure, oral ‘flow management’ discourse found in the Phase III sub-study. The effect in practice of such contradicting discourses emanating from the same source, the state employer, and even of the absence of reference to the vital importance of the resource availability factor in other sets of mental health triage guidelines, deserves attention in practice and in research.
APP C.1.4 DE-PROFESSIONALISATION

The study generated evidence that, while psychiatrists bear ultimate responsibility for the quality of the exercise of statutory powers, their capacity to acquit these responsibilities satisfactorily may be affected by another range of practices that ‘de-professionalise’ services within public mental health facilities. At the centre of this de-professionalisation strategy of the state is the greater prominence of multi-disciplinary teams:

Informant: Now in the great multidisciplinary world...which is non-medicalised, there are people put in positions where they have great anxieties about decision-making and responsibility because that’s not [properly] their guilt.... for a lot of other professions, even though they call themselves professional ....they don’t have the apprenticeship of the responsibility of decision-making.

Interviewer: Do you say there’s more of that now than there was?

Informant: Oh yes...you can see this in the [UK] literature, there is this kind of standard modus operandi of ‘The Team’ now.

[emphasis added]

(Male, 55+)

Several clinicians referred to the imposition of clinical protocols, by health service management, which significantly affected their practice and decision-making, and in one case was thought likely to be anti-therapeutic, with no consultation with the psychiatrists themselves:

Similarly, these forms ....which were introduced four weeks ago. There was no consultation.....They are coming out and saying ‘you will all do this.’ But is there no way they can sit with the clinicians...in a dialogue? Isn’t there a better way to do this? The people who are advocating for these [changes] just have one approach—‘we’re going to ask you to do this.’

(Male, 41-54)

There are either fake efforts at consultation or none at all...In the [X] months [of my employment] not one document has come across my desk—a discussion paper or the like—which seeks consultant input on how things might be improved.

(Male, 25-40)

Psychiatrist informants see their professional authority waning through the increasingly managerialist approach of hospital administrations, the greater involvement of community-based services, and the rise of ‘nurse power’.

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Informant: I love nurses. I have the highest respect for them. But you know I think nursing staff have a much, much higher [trails off]...Male and female, it’s not a gender issue ......kind of control, if you like...

Interviewer: More power?

Informant: Yes more power. They’ve got the numbers.

[Male, 41-55]

Informant: At that time [the consumer will] confront the admission office, staffed by nurses, an after-hours bed manager and a registrar who is then called in. It depends on the registrar’s seniority whether he or she will exert his or her authority. Or do what they’re told by the others...

Interviewer: Is there a ‘boss’ of the ward?

Informant: There’s a nursing structure. And the clinicians tend to be less structured... the nursing staff are much more organised, have a much stronger structure. They have a senior person on the ward. And that sets the atmosphere of the ward. And the nursing staff would tend to support the culture of the organisation...

[Male, 55+]

Informant: There’s a lot of focus on change and change management... Non-government organizations taking more responsibility and the profession taking less responsibility... and also there’s a reduction of medical input, in our particular areas since we’ve become, and I shouldn’t say this, but since we’ve become dominated by nurses.

Interviewer: Does that [change and nurse ‘domination’] result in less positive outcomes for the patients?

Informant: It might, be given that we have such patients here ... I think many of our nurses are highly skilled but they haven’t done the training... it’s all a bit of a concern.

[Female,41-55]

It is clear from these transcript excerpts that the psychiatrist informants in the study were not merely reflecting on a particular structuring of their participation and decision-making by virtue of their employment, like any other employees seeking to make sense of their place in the hierarchy of the workplace. Instead they were, with some bitterness, reflecting on loss—of an authority and autonomy that, historically and professionally, they had once possessed and valued.
APP C.1.5 ‘ALIGN WITH THE SERVICE’ DISCOURSE

A number of clinicians interviewed spoke about what they experienced as pressure, in the form of an unwritten condition of their employed service, to support and protect the public profile of their mental health facility employer. This vector of influence, a largely though not entirely oral discourse, is leveraged obliquely through the combined effect of the technologies of employment, and of the technology-of-the-self (that a ‘good’ public psychiatrist has a primary normative alignment with the employing state service).

There was acknowledgment from informants that pressure to minimise service limitations ‘came with the territory’ of public psychiatric employment. Two clinicians explained that loyalty to the system, in the form of compliance with such pressure was necessary and justifiable:

As part of ...public service rules we can’t just go public about concerns, and in a way I am not surprised that the organisation has rules about this because it would not be helpful if everybody just said what they thought to, for example, the media. I do believe this is also related to the issues of leadership and how supported staff feel, but I don’t really want to go into this.

[Female, 41-55]

Informants described a number of practice expectations leveraged through the ‘support and protect the service’ discourse including:

requirements to minimise perception of service limitation:

...in fact the language of service limitation has taboos on it. You’re not allowed to say—you can’t say—’you can’t have this here’

[Male, 41-55]

to document on risk defensively:

I will use the analogy of nursing homes and the way that they’re accredited. Accrediters come into nursing homes and they base their assessment of how good the nursing home is on how well they document everything. Not on the care that’s actually provided but on the documentation that evidences that care is being provided.

[Male, 55+]

and, in at least one jurisdiction:
to minimise the likelihood of negative media attention:

Because we’re such a very risk-averse jurisdiction, I think some people probably
don’t get discharged .... It depends on the ...on how high profile they are. Once
they’ve, if [their admission is reported in the local newspaper] they won’t get
discharged.

[Female, 41-55]

It’s not just the coronial process. It’s partly political, especially [here]. ... Where
people just go into [the newspaper offices]. I do think that influences people’s
practices and I think it shouldn’t, but it does.

[Female, 25-40]

Informants experienced pressure to conduct their practice so as to preserve the ‘good
name’ of state’s mental health service, notwithstanding that such practice might not reflect
the reality of services provided, and indeed, that such practice might, in fact, detract from
capacity to provide service. This discourse is conveyed through the joint action of the
technology of employment and, very powerfully also, through the technology-of-the-self,
as discussed in APP C.3 supra.
APP C.2 ACCOUNTABILITY PROCESSES

The Phase III sub-study also identified ‘accountability processes’ as a technology of power associated with the technologies of law but not directly engaging them.

Accountability processes, for these present purposes, include:

- the delegation of conditional powers or duties to compulsorily treat and detain;
- in-house processes such as complaints handling, critical incident reviews, root cause analyses, performance reviews, record-keeping protocols, duty statements, practice memoranda, delegation protocols, clinical guidelines, chief psychiatrist’s investigations and professional misconduct inquiries, and
- external processes such as coronial enquiry, various reporting protocols, health service-wide ‘sentinel event’ programs, and independent enquiries ordered by government and common law litigation.

Figure C2
Vectors of influence engaging accountability technologies
The Phase III sub-study found that two vectors of influence, ‘responsibility for compulsory treatment and detention’ and ‘blame for adverse events’ were transmitted by the technology of one or more of these accountability process across the A1a governmentality assemblage.

**APP C.2.1 ATTRIBUTION OF RESPONSIBILITY FOR COMPULSORY TREATMENT AND DETENTION**

The responsibilisation of psychiatrists engendered by the accountability group of processes sits in contrast with the effect of ‘de-professionalisation’ identified previously. Yet both vectors of influence are extended by the state at once. The effect is to generate one of the paradoxical findings of the Phase III sub-study, namely that: informant psychiatrists are responsible for professional decisions made under powers granted to them under relevant mental health law, but are unable to control the making and quality of those decisions.

Reports from the study suggest that there is growing disjuncture between the multidisciplinary team culture that effectively disempowers psychiatrists, and the responsibility, powers, and ultimately the blame for untoward events ascribed to ‘responsible’ practitioners under mental health law:

> The other thing is that in the Coroner’s Court, if something bad happens, everybody will be asked to give an opinion, but the ultimate... responsibility is with the consultant psychiatrist...[Psychiatrists] will say: ‘I can’t say I discharged the person because the nurse told me’. You have to talk about ‘The Team’—that ‘The Team’ made the decision....Then, there’s a sort of strong question by the lawyers, saying ‘don’t worry about The Team, did you feel that was the right decision?’... So it, sometimes it’s a very difficult situation. On one level you are accountable for that big decision you make but some days you are not able to make decisions. It’s a very awkward situation.

[Male, 41-55]

The other way of alleviating this is kind of anxiety or responsibility is to...[try to] diffuse the responsibility....to enter ‘the team’...“Oh, this is a team decision”. But then: “Well, actually, I told the consultant, therefore the consultant is responsible”.

[Female, 41-55]

That’s one of the methods ... they try and channel this sort of responsibility to consultants. Which is absurd. Believe it or not but in [city region] there are 70 full-time people of which 3.3 are consulting psychiatrists. So, if you want
70 people to channel their responsibility to 3.3—well, they can do that I guess, but it’s completely absurd to think that the psychiatrists can be responsible for patients they’ve never heard of.

[Male, 40-55]

The team is non-medical and everyone’s equal except when the shit hits the fan. Then it goes to the consultant.

[Male, 40-55]

**APP C.2.2 BLAME FOR ADVERSE EVENTS**

The phenomenon of blame is identified in this study as a separate vector of influence, despite that it is closely related to formal clinical responsibility—blame might be thought of as the ‘pointy end’ of responsibilisation. Many clinicians spoke about the particularly deleterious effects of the blame vector on their practice and sense of themselves. These effects are described in the sections on ‘Actions externally’ and ‘Actions-on-the-self’ of this thesis.

The role of blame in accountability processes in health systems has been investigated extensively (Brennan et al., 1991; Goldmann, 2006; O’Connor et al., 2011a; O’Connor et al., 2011b; Runciman, Merry, & Tito, 2003; Wachter, 2010; Wachter & Pronovost, 2009). This literature identifies that a balance between ‘no blame’ and punitive accountability measures as an ideal for the mental health sector.

In the Phase III jurisdictions, it appears that this ideal is still to be realised. The study identified that current arrangements of responsibility and accountability in the Phase III jurisdiction mental health systems are very far indeed from a ‘no blame’ culture. The following informants colourfully confirm Nick O’Connor’s description of blaming as the process of identifying ‘the problem’ as being “in another person” (O’Connor et al., 2011b, p. 115).

There’s things called RCA’s...root cause analyses which [name] refers to as the WFU investigation—’Who Fucked Up’.

[Male, 55+]

I think working in the public system you have to give up some of that autonomy and we do work much more in teams and...it does feel to some extent as if the ultimate responsibility is yours rather than the team’s. So you kind of have to work with other people and that works fine. It doesn’t bother me except...at the
end of the day, you know in some teams I've worked in...I've thought, like, really, when the pointy bit arrives, it will be pointing at me.

[Female, 41-55]

Several clinicians referred to blame as an increasingly prevalent and intrusive negativity in their working lives:

Being increasingly intolerant of any risk and the consequences of blame (by the service, by the coroner, by the family, by the public etc) if incidents do arise, is an increasing problem, and leads into the unclear area of individual v. clinician v. service responsibility.

[Female, 41-55]

Informant: I think one of the things that’s happening about the consequences of the Act that is becoming the major preoccupation for me—I’ve been in quite a lot of enquiries now, which I’ve never been in before. I’ve had quite a lot of RCAs....The whole issue of the decision that you’re making, the consequences has become...one of the biggest things for me to worry about.

That’s becoming one of the more serious consequence I think, in the sense that the procedures that are required now, means that every adverse event ends up in some sort of incident enquiry -

Interviewer: Is that becoming more so in the last 10-15 years?

Informant: Definitely.

[Male, 55+]

Informants reported particular concerns about they saw as the blame-allocating mission of coronial inquiry. The purpose of a coronial investigation is to investigate and make findings about the causes of sudden, violent, suspicious or unnatural deaths (ss. 3 and 17 Coroners Act, 2009 (NSW)). Informants did not see this purpose as sitting well with the possibility of ‘blameless’, even if wrong, decision-making:

[T]he coroner kind of makes grand statements about what should happen and who did wrong in a way that really doesn’t demonstrate....that suggests that mistakes were made that shouldn’t have been made, rather than....even if you make the right decisions to the best of your ability!

There is mismatch between what the coroner reasonably expects psychiatrists and psychiatric services to be able to do, and the [fact] that the resources aren’t there...
How does a ‘technology-of-the-self’ work?

‘Technologies-of-the-self’ are exercised, in the present case, by the state, upon the subject psychiatrists to “effect…operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves” (Foucault, 2003e, p. 146). The objective in the use of a technology-of-the-self by the state is transformation of the psychiatrist’s self in the direction of an identity that is more likely to generate behaviour consistent with the aims of the regulating state.

It is part of the complexity of the practice of public psychiatry that technologies-of-the-self—being the transmission of elements of portraiture about how a ‘good public psychiatrist’ should be or behave—are dynamically in play alongside, embedded within, or intertwined with the use of all of the other technologies of power exercised by the state upon the public psychiatrist stakeholder.

Composition of the operative technology-of-the-self in Assemblage A1a

The technology-of-the-self being the promulgation of ‘good public psychiatrist’ profile appears to be comprised of a collection of cultural memes. Informant data suggested three principal elements of the characterisation of the ‘good public psychiatrist’ comprising the technology-of-the-self, propounded by the state, as a vehicle for transmission of each of the vectors of influence identified as in play in the A1a assemblage. These elements were: ‘I align with state service values’, ‘I accept reduced professional autonomy’, and ‘I tolerate risk of blame for adverse events’.

The results suggest that these elements of the ‘good public psychiatrist’ technology-of-the-self are likely to transmit as much, or perhaps even more, influence than the mere obligation to comply with direction, attend to organisational protocols, or to perform duties in a particular manner, as required by the other operative technologies in Assemblage A1a.

‘I tolerate risk of blame for adverse events’

Informants psychiatrists reported that they bore a daily burden of awareness of the risk of criticism and blame that would resile to them personally in the event that a patient committed a violent act whilst under, or subsequent to the provision of, their care.
You have to be able to tolerate a certain level of risk or you couldn’t do the job.

People come in with lots of problems—dysfunctional family and drugs. They come to you, if you don’t fix it, it’s your problem. You say: “I can help”. “No, no, no doctor, you fix it. If you don’t fix it you are a bad psychiatrist.” It is the general understanding.

I think it’s gone crazy actually, it leads to that being the sole—I don’t see this much in people of my generation, it’s the people coming through. There is so much focus on risk assessment, and this—that you can’t possibly make any mistakes [emphasis original].

The machinery of the state’s devolution of blame to psychiatrists is comprised in the technology of the accountability systems described previously. But the characterisation of the identity of the ‘good public psychiatrist’ as one who is prepared to bear risk of blame occurs much earlier than, and without the necessity for, the flowering of a contingency generating the action of that machinery. The strength and breadth of effectiveness of the ‘accept blame’ vector of influence, then, depends on both of the contingent technology of accountability, and its accompanying technology-of-the-self, being the promotion of preparedness to accept blame as part of the self-identity of the ideal public psychiatrist.

‘I accept reduced professional autonomy and respect’

Phase III sub-study data revealed an understanding by public psychiatrists that they were now expected to accept less autonomy and respect for their clinical judgment than they might have had in the past, or is still enjoyed by their colleagues in private practice.

Informant: I think firstly they make you practice in a way that you yourself find unacceptable or can do nothing about. Secondly they make you feel powerless and that’s the lack of autonomy...

Interviewer: How do they make you feel powerless?

Informant: Well they make you feel powerless in that you know what would be best for a patient and you just can’t do it. Any decision you make after that is like a compromise.
Again it comes back to autonomy, having less autonomy here and feeling less in control of your destiny...

[Male, 25-39]

I think working in the public system you have to give up some of that autonomy and though we do work much more in teams you don’t always feel as if—it does feel, to some extent, as if the ultimate responsibility is yours rather than the team’s.

[Female, 40-54]

Psychiatry, in particular, has been de-medicalised...In the past, the proportion of doctors was higher, and they had more authority.

[Male, 40-54]

Not that I—I’m kind of an egalitarian person so I kind of like not being, not putting in input all the time—However, I think that it needs to be more balanced, and we need ultimately to say ‘we all have our jobs and our careers’. And because it’s the needs of patients that should dictate everything, not someone saying ‘this is my baby of a policy’...

[Male, 40-54]

As another example of the tandem operation of technologies of power, the Phase III sub-study found that the imposition of multi-disciplinary workplace protocols, discussed previously in relation to the technology of de-professionalisation, is accompanied and supported by a technology-of-the-self. The effect is that public psychiatrists are expected to accept less authority in their clinical decision-making than their training, private practice experience, and the history of their profession, might have led them to expect.

‘Support and protect the service’ discourse
As has been discussed, it appears that all of the vectors of influence identified in Assemblage A1a are conveyed by the combined action of technologies. It is possible that the combined action of the technology of employment, and the relevant technology-of-the-self, is a particularly potent combination. The Phase III sub-study identified a third aspect of the ‘good public psychiatrist’ technology-of-the-self, being the attribute ‘I align with hospital values’—if necessary over the psychiatrist’s own interests, and the interests of the patient.
Well, [my aim] would be to help people in hospital until you actually take care of the symptoms well enough, rather than just have them patched up well enough to get them out. But that’s what the organisation itself is set up for, the hospital...for security and risk minimisation, rather than for treatment and best outcomes. Generally those things take precedence over traditional clinician’s values.

[Male, 55+]

Interviewer: Because the pressure in your own workplaces is on your own positions and people’s careers?

Informant: People are worried about seeming to be a redneck or radical or whistleblower or whatever.

[Male, 41-55]

Well, I think this is the way—they [the state service] just want people to do the job, they don’t want people who are going to change the way things work. There’s no motivation for them to make people happy about their clinical experience. They’re interested in keeping good staff—maybe—or at least, people that are functional. But if you want change, or you don’t like the way things are going, which I think is dealing with accountability and transparency, they don’t want you in the system.

[Male, 55+]

The Phase III sub-study identified the operation of a technology-of-the-self in the form of a promoted profile of the ‘good public psychiatrist’. This technology was found to frequently accompany other technologies of power to convey the operative vectors of influence in Assemblage A1a. The three principal attributes of this identity, as found, were: ‘I tolerate risk of blame for adverse events’, ‘I accept reduced professional autonomy and respect’ and ‘I align with hospital values’.

This characterisation is striking in its lack of internal cohesion, indeed of the contradictions and conflicts inherent in it. The state asks psychiatrists to tolerate risk of blame for decisions and at the same time accept the devaluation of their autonomous, decision-making authority—that is, of their very capacity to make the decisions for which they will ultimately be responsible. The state also asks psychiatrists to align their values with their employer, the state, which values in practice are, from time to time, in direct conflict with patient needs and best interests that the psychiatrist-doctor-selves have, in another time, sworn to uphold.
Appendix D: Directions for reform

...the total fabric of the web of private and public controls has quite profound effects... Law is important to holding that fabric together. Strategic regulatory action that has big effects... involves having the wisdom to know what is the right strand to pull at the right moment to tighten the web. And knowing which strands of control when pulled too forcefully will cause the whole web to unravel. In a majority of cases, legal strands will not be the most crucial ones which, when tugged, have the biggest effects... But it would be wrong to conclude... that the same result would apply if law were not part of the fabric of the web. Again this leads us to the virtues of seeking a holistic understanding of how whole webs of regulatory controls interact.

(Parker et al., 2004, p. 274)

As has been noted previously, the scope of research focus for this thesis does not include design of an alternative regulatory structure for the mental health policy domain. To progress the project from the findings of the mixed-model study to alternative state policy requires significant further analysis, and design and testing of alternative models. Several directions for future design are suggested by the results however.

What reform?
The reform directions suggested in Table D1 have three specific and yet overlapping foci:

- defusing the risk discourse;
- de-medicalising the control of offenders, and
- re-medicalising civil psychiatric practice.

The directions specifically address the pragmatic formulation of the state’s problematisation of access to mental health as developed in the Conclusion to this thesis. This is:

How to provide public mental health service such that the Australian community feels sufficiently safe, and is otherwise reasonably satisfied with provisions for access, for the lowest possible cost?

It is assumed that the current conditions of scarce resources, mismatch of demand for and supply of public mental health services, and public concern with safety and security will either remain the same or amplify into the future.
## Table D1

### Summary of alternative policy directions

<table>
<thead>
<tr>
<th>Policy Aim</th>
<th>Type of measure</th>
<th>Projected Outcomes</th>
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<tbody>
<tr>
<td><strong>Increase the range of regulatory responses</strong></td>
<td>Institute a wider range of regulatory interventions between the assumption of voluntary compliance and enforceable involuntary treatment. Employ capacity and best interests criteria for involuntary treatment of civil consumers and non-serious offences. Employ risk criteria for serious offences.</td>
<td>Fewer mental health orders and less legalism. Lower cost. More voluntary engagement by consumers. Increased consumer responsibility. Less psychiatrist responsibility.</td>
</tr>
<tr>
<td><strong>Decrease continuing costs of chronic mental illness</strong></td>
<td>Establish residential step-up and step-down facilities. New approaches to asylum. Increased support for carers and community health centres, integrating mental health and related social services. Increased participation in service design and provision by recovering consumers and the community sector.</td>
<td>More services, better distributed, cheaper to run. More effective servicing for chronic conditions. More integrated social services. Less ‘rowing’ by the state. Less crime, incarceration.</td>
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Policy direction 1: Increase the range of regulatory responses

The first set of measures, aiming to increase the range of regulatory response, attends directly to the lack of proportionality and responsiveness in the current regulatory design. But mental health services could operate from a default policy position that the consumer possesses mental capacity and will voluntarily comply with treatment recommendations. Regulation towards consumer engagement and compliance, if this is needed, might then escalate through other non-legal interventions such as current evidence indicates may be effective (such as coordination of housing and other social services, carer involvement, warnings and directives, the use of advance statements, enforceable voluntary undertakings and assertive community treatment). Different legal criteria for involuntary treatment is suggested for civil and forensic consumers respectively.

This scope of measures genuinely operationalises an increase in the role and responsibilities of the consumer in the recovery process. It represents a re-setting of the regulatory relationship more directly as between the state and the consumer, whilst retaining scope for escalation to the highest present levels of enforceability. Protection for the consumer lacking mental capacity is retained.

This set of regulatory measures removes the legislatively-sanctioned domination of the risk and deficit focus at the heart of the mental health system.

Policy direction 2: Distinguish forensic and civil mental health service streams

Policy direction 3: Decrease continuing costs of chronic mental illness

The suggestions in Policy directions 2 and 3 relate to non-regulatory policy measures to support the suggested revised regulatory design. The aim of the second range of measures is to separate the treatment and ‘control’ functions of psychiatry as much as is feasible, and to re-establish the primacy of holistic medical norms in civil mental health services (with accountability measures as necessary).

The third range of measures seeks to make further savings in the balance of the

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26 With appropriate protections for the so-called ‘Bournewood’ patient type (non-capacitous yet compliant).
system—in the direct costs of chronic mental illness (e.g. repeated, unnecessary and ineffective engagement of expensive acute care facilities; human suffering) and indirect costs (e.g. costs of criminal and correctional processes; more acute general health difficulties).

Policy direction 4: Increase community involvement

The fourth range of policy measures—those designed to improve engagement with the community—are crucial for both for the effective management of scarce resources, and to address public fears and uncertainty, particularly in the context of policy change. The Australian community needs *continuing* education to reduce its misapprehensions about mental illness, about the ability of psychiatrists—or indeed, anyone—to predict adverse events, and to develop community recognition that the only way to ensure fewer adverse events is to improve the standard of care overall.

The public can be brought to greater responsibility for the effect of scarce resources on the universal health care ideal—and particularly in relation to mental health servicing. The findings of the mixed-model study suggest that reducing the role of the risk criteria would remove what is currently a critical, if inappropriately employed, tool for control of access to the system at its threshold. In the implementation of the tranche of policy suggestions set out in this Appendix, medical discretion would again operate in the place of risk: the neediest consumers, as assessed by clinicians, would be the first to absorb available resources. But as the mixed-model study also noted, the informal triage that takes place around the notion of ‘need’, in a void of guidelines explicitly addressing a service context of permanently mismatched demand and supply, has potentially negative and inconsistent outcomes.

It is not the place for individual practitioners, or even individual facilities, but *is* properly the role of the state and the community jointly, to decide how inadequate—possibly permanently inadequate—health resources should be applied (Malone, 1998). Exactly how health policy planners currently make decisions about health care priorities is not well-understood. It is known, however, that the views of the community are not yet routinely incorporated (Robinson, Dickinson, Freeman, Rumbold, & Williams, 2012).

Best policy practice now firmly encourages collaborative initiatives with considerable research on methods of integrating public input in the ordering of social and health services (Marris & Rose, 2010; Mitton, Smith, Peacock, Evoy, & Abelson, 2011; L. Williams, Phillips,
Nicholson, & Shearer, 2014). Such initiatives can range from simple surveying, to traditional ‘stakeholder consultation’, to various styles of community fora (including web-based), through to large public deliberative democracy events, and purposeful engagement of the public in research (Alderman, Hipgrave, & Jimenez-Soto, 2013). It is suggested that such methods be engaged to promulgate wider public discourse on the funding of mental health (perhaps relative to other health priorities); on the distribution of resources within the mental health sector; and to develop guidelines on how relative need, including social need, should be factored and responded to at the hospital or health centre door.

Conclusion

The package of policy measures suggested for the reconditioning of the regulatory design in the mental health sector, in the light of understanding gained in the mixed model study, would represent improved outcomes for all stakeholders, and for the work of the mental health domain as a whole. It also attends to the conditions of the times.

The new regulatory design would be more responsive to the interests of almost all stakeholders, with the exception of the relatively small population of forensic consumers. It would more relevant and effective by its significant defusing of the damaging power of the risk conceptualisation within the services (Parker et al., 2004). The revised regulatory scheme, with its additional layers of escalated non-legal to legal measures, would be considerably more proportionate and commensurate to the various capacities and motivations of all stakeholders, including the consumers whose compliance it seeks to secure.

Designed with a refreshed view of the state’s problematisation for mental health regulatory policy, the revised regulatory design directly addresses both on-going cost control and the risk concerns of the electorate. At the same time it removes barriers to the exercise of capacity by both psychiatrists and consumers to enable both of these stakeholders to achieve more of their own goals, and to contribute more significantly to the achievement of positive outcomes for the sector as a whole.