

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

Chapter 7

Negotiating epistemic rights to knowledge concerning service users' recent histories in mental health meetings

Kirsi Juhila, Lisa Morriss and Suvi Raitakari

Published in Kirsi Juhila, Tanja Dall, Christopher Hall and Juliet Koprowska (eds.) [Interprofessional collaboration and service user participation: Analysing meetings in social welfare](#). Bristol: Policy Press, 171–195.

Introduction

Face-to-face interactions between professionals and service users are central to mental health services. Participants jointly seek, gather, produce and assess knowledge about concerns, risks and troubles that need to be addressed, for example, mental health, financial and interpersonal issues. Social work and health care are often conducted in multi-agency settings and meetings where professionals from different disciplines and service users address each other. In multi-agency meetings, mental health service users are both talked to and talked about, and they also describe their own situations and experiences. This creates a sensitive interactional task for professionals. Professionals need to express such knowledge about the service users that they deem relevant to tackle the issues at hand and make judgments in situations where service users are co-present as listeners, yet also co-producers of knowledge. Producing and using knowledge is bound to epistemic rights, to the 'distribution of rights and responsibilities

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

regarding what participants can accountably know, how they know it, whether they have rights to describe it, and in what terms' (Heritage and Raymond, 2005, p 15).

This chapter studies how knowledge of service users' recent histories and their experiences is produced, presented and used in statutory Care Programme Approach meetings in England. The participants in the meetings are service users, their care coordinators, housing support workers and psychiatrists. The analysis displays which participants in this multi-agency interaction epistemically own knowledge about the service users' recent pasts. What makes the ownership of this knowledge interesting is that despite dealing with service users' personal histories, at times, it is the professionals who hold this knowledge based on their previous interactions with a particular service user. Thus, in analysing the meetings, we are interested in how professionals present themselves as knowledgeable about the service user's history, and how service user participation is realised or not on these occasions.

The Care Programme Approach

The Care Programme Approach (CPA) was introduced in 1991 as a statutory framework for people requiring support in the community for more severe and enduring mental health problems (Department of Health, 1990). The framework has four main requirements: a systematic assessment of health and social care needs, the formulation of a care plan to address these identified needs, a named key worker (now called a care coordinator) to coordinate the care plan, and regular reviews to ensure that the care plan still meets the needs of the service user. The CPA was modernised (Department of Health, 1999) with the focus on integrating the CPA and care management, more consistent implementation of the CPA nationally, streamlining the CPA process to reduce the burden of bureaucracy, and achieving a proper focus on the needs of service users. Carpenter et al (2004) interviewed 260 mental health service users

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

on CPA registers in four districts in the north of England. The majority of these participants (230) were then re-interviewed six months later. During the first interview, approximately half of the service users knew that they had a written care programme. Most participants who knew of the care plan held positive views; approximately 90% agreed with their care plan, thought it was clear and comprehensive and addressed their needs. In terms of the CPA review, over half of the users in Districts A and D but only one-third in Districts B and C attended such meetings.

The Department of Health published a consultation paper in 2006 with the aim of enhancing the effectiveness of the CPA process. The paper acknowledged concerns that instead of enabling real engagement with people, the process was rigid, inconsistent and a managerial ‘tick-box’ tool. In addition, mental health service users felt that they were not involved as partners in the process, and the emphasis was on problems, risk and treatment, rather than a strengths-based approach towards recovery (Department of Health, 2006). Following this, the CPA was revised in 2008 to refocus on people in contact with secondary mental health services with ‘complex characteristics’ (Department of Health, 2008, p 11). These ‘characteristics’ are set out in a table in the 2008 Guidance and include: a severe mental disorder with a high degree of clinical complexity; current or potential risk(s), including a risk of suicide, self-harm, and harm to others; and a current or significant history of severe distress/instability or disengagement. A person with one or more of the ‘characteristics’ has a named care coordinator and an initial comprehensive multi-disciplinary, multi-agency assessment to formulate a care plan, which is then reviewed at least once a year at a formal multi-agency CPA review meeting. This care plan should include explicit crisis and contingency plans, and support for any physical health needs. In this revised form, the CPA resonates with the prevailing policy of collaborative and integrated care that is expected to respond to service users’ complex problems and needs with a comprehensive care plan that is regularly reviewed in multi-agency meetings (see Chapter 2 in this book). It also seems to rely on the idea of

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

relational agency, emphasising that interactions among various professionals and service users produce solutions to complex problems that are more than just a combination of individual professionals' and service users' expertise and interpretations of problems (Edwards, 2011; see Chapter 2 in this book).

The new guidance included a Statement of Values and Principles (Department of Health, 2008, p 7), stating that this approach to individuals' care and support 'puts them at the centre and promotes social inclusion and recovery'. However, Gould (2013) found that CPA care plans predominately emphasise clinical outcomes, medication and risk. Indeed, Tew et al (2012, p 455) argued that there needs to be a fundamental paradigm shift where an individualised 'treatment-oriented' approach such as the CPA is replaced by a recovery-oriented approach, 'in which working with family and friends, and promoting social inclusion, are no longer optional extras'.

Finally, the 2016 National Community Mental Health Survey undertaken by the Care Quality Commission had responses from 13,200 adults receiving specialist care or treatment for a mental health condition. Of these adults, 29% had their care coordinated under the CPA. In terms of knowing who was in charge of organising their care and services, 88% of the CPA respondents had been given this information. Only 52% of the CPA respondents had 'definitely' agreed with the mental health services about the care they would receive, 82% said their care had been reviewed in the previous 12 months, and 80% knew whom to contact out of office hours in a crisis. Less than half of the CPA respondents (43%) answered that they had had help or advice with finding support for physical health needs in the previous 12 months, and only 43% 'definitely' received help or advice with finding support for financial advice and finding or keeping work. Lastly, only 38% of the CPA respondents had 'definitely' had support from mental health services to enable them to engage in a local activity. To conclude, according to various reports, it appears that the CPA process still has problems from the point of view of service users and in terms of their participation.

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

Furthermore, research on how the CPA is accomplished in interactions between service users and professionals is lacking. Hence, there is a need for a detailed study of frontline practices of the CPA. This chapter deals with one of the core CPA practices, namely, the multi-agency meetings (CPA meetings) where service users' situations and future steps in their care pathways are reviewed and discussed. In analysing these meetings, special attention is paid to knowledge production. What and whose knowledge is in focus and considered valuable is consequential in generating 'common' knowledge in these meetings. In particular, how service users are treated as participants in creating knowledge concerning their own lives is reflected in whether the meetings resemble degradation ceremonies or integration ceremonies (see Chapters 2 and 3 in this book).

Epistemic access and rights to service users' recent histories

This chapter asks how knowledge of service users' recent histories is produced, presented and used by the participants in their interactions in CPA meetings. Specifically, the focus is on which participants seem to epistemically 'own' this knowledge by displaying themselves as having direct and primary access to it and also having rights to present and use it as 'experts' (on epistemic rights in conversations, see Heritage and Raymond, 2005; Raymond and Heritage, 2006; Heritage, 2012). 'Owning' knowledge is connected to participants' epistemic statuses in interactions. According to Stevanovic and Peräkylä, (2014; see also Rautajoki, 2010):

The term epistemic status refers to the position that a participant has in a certain domain of *knowledge*, relative to his/her co-participant(s). It is one facet of the participants' momentary relationship. It is based on the participants' common personal history, while being shaped by the cultural and institutional expectations of who should know what, and about what. Importantly, however, epistemic status is continuously modified in the turn-by-turn sequential unfolding of interaction, as participants share their knowledge with each other. (italics in original) (Stevanovic and Peräkylä, 2014, p 189)

Epistemic statuses in the CPA meetings are thus displayed and modified in turn-by-turn sequential interactions. However, there are some cultural preconceptions about who is assumed to have access and rights to certain domains of knowledge. In everyday conversation, participants are treated as having privileged access to their own past experiences and the associated right to knowledge claims about these experiences (Pomerantz, 1980; Sacks, 1984; Heritage and Raymond, 2005, p 16). In professional-service user interactions, service users are also supposed to have epistemic authority ('ownership') of their own inner thoughts and experiences as well as knowledge of their personal life histories, whereas people in the medical, psychological and social work professions, among others, are expected to possess knowledge because they have educational qualifications based on these domains of knowledge. In the course of (inter)professional-service user interactions, participants usually orient to these assumed epistemic authorities. For example, in a social worker-service user interaction in mental health, a worker can say, 'How are you feeling?' and in this question format, cedes the ownership of inner feelings and their assessment to the service user him/herself (cf. Heritage and Raymond, 2005, pp 21–22). Alternatively, the service user can orient to the worker's epistemic authority by asking, 'Do you think I need some therapy in order to overcome this crisis?'. Ekberg and LeCouter (2015) give an example of the differences between assumed epistemic authority in therapy settings:

Making proposals for behavioural change may inadvertently create a dilemma for therapists. Although they carry the authority of a professional perspective, therapists only ever have secondary access to knowledge about a client's life and situation, based on what the client has shared within the therapy session. Clients will always have the ultimate epistemic access to how situations have played out in their lives, and how their behaviour may affect their situation in the future. (Ekberg and LeCouter, 2015, p 13)

However, in the CPA meetings, epistemic authority regarding the service users' personal life histories and related experiences appears to be shared with some of the professionals present, as care coordinators and housing support workers may orient to this knowledge and thus display that they have access to it.

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

The professionals do indicate in their turns that they have had direct access to the referent states of the service users' recent personal histories. The professionals' knowledge and right to make statements concerning the service user is then based on the assumption that they have been present, seen and experienced the service user's reality.

Data and the process of analysis

The material in this chapter consists of three CPA meetings that took place in England. The meetings were audio recorded with the consent of all the participants and then transcribed as part of a larger project examining service user-professional interactions in mental health in England and in Finland¹. The participants present in the CPA meetings are the service users and their care coordinators, the support workers from the service users' current supported housing services and psychiatrists. Psychiatrists act as chairs in two meetings with a care coordinator chairing the third meeting, as the psychiatrist was unable to attend.

CPA meetings are organised in a question-answer format based on an official form that the chair follows in order to thoroughly discuss all the required topics and assess the possible risks, thereby fulfilling the pre-specified organisational purposes and institutional task of the meetings. In this sense, the meetings have a rather formal and ritualistic structure (see Chapter 3 in this book). Overall, the participants in the meetings seek to coordinate the services, assess the past, and plan forthcoming steps and interventions in the service users' pathways and future lives in general.

The analysis of the three CPA meetings was commenced by highlighting the sequences where the service users and professionals refer to the recent histories of service users. Such sequences were present in each of the three meetings. In total, 41 sequences of this kind were identified. These mostly began with a

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

question posed by the chair to the service user. For example, the questions invite the service user to describe what they have done recently, how they deal with everyday affairs, for example, cleaning, money matters, what kinds of close relationships they have, how well they have felt mentally and physically, what medicines they take, and whether their services are appropriate for them.

As the questions from the chair involve the service users' personal matters, the service user should be ceded epistemic authority in having privileged access to the information and the associated right to answer the question. However, professionals, especially the support workers but the care coordinators too, also often present themselves as knowledgeable about the service users' recent personal matters. Based on this core finding, a key research question of the study is 'How do mental health professionals produce, present and use knowledge whose epistemic rights can be regarded as belonging to the service user?'. Following Heritage and Raymond's (2005, p 34) proposal to identify 'a variety of practices that are deployed in managing these epistemic claims', six devices were identified through which the professionals produce, present and use knowledge of the recent histories and past experiences of the service users. They were present in all three CPA meetings. These devices are:

- confirming service users' personal knowledge;
- adding some knowledge to service users' personal knowledge;
- fishing for personal knowledge from service users;
- producing positive assessments of service users;
- producing knowledge on behalf of service users;
- challenging service users' personal knowledge.

In the next section, four illustrative extracts from the CPA meetings are analysed. The extracts demonstrate the above six devices and the ways in which the professionals use them in producing

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

knowledge of the service users' recent histories, thus displaying that they have some epistemic authority for this knowledge. In analysing the extracts, attention is also placed on whether the talk on the service users' recent histories is discussed jointly among the professionals and the service users or not.

Analysis: displaying epistemic rights regarding service users' recent histories

'Aligning talk' about positive changes in the service user's recent life

The first extract is taken from the meeting with Tim, a man in his 20s and currently living in supported housing. The sequence begins when the chair asks Tim if he has any "worrying debts".

Extract 1

1. Chair: Okay, do you have any worrying debts that you?
2. Tim: No, I don't at all. I always pay my bills on time.
3. Housing support worker: Brings me the receipt every two weeks.
4. Tim: Just going back to ((previous unit)), a lot of people were always asking me for money and pressuring me for money as well, like abuse, financial abuse and that, and actually, I don't get that right now at ((present supported housing unit)), so I've always got my money to myself now. Do you know what I mean? So, that's even better. They were just using me for money all the time, always asking, knocking on my door at two o'clock in the morning asking for a fiver, and you're saying, away man. Do you know what I mean?
5. Care coordinator: So that is something (..)
6. Housing support worker: And this is one of the things that concerns us.
7. Care coordinator: That we always talk about because, Tim, you don't like to say no to people, but it's not been an issue at ((present supported housing unit)).
8. Tim: The concern is to get my own place; I don't get involved with people that take smack or drugs and that, but like I say, with my own place, I'll obviously get support off you lot. I know that, yeah, but like otherwise my mum and stepdad and Eric ((unclear)), I'm not going to have loads of lads in now, have like a drugs sesh, I'm not like that.
9. Housing support worker: I know you're not.
10. Care coordinator: But you made that change, you cut the people out of your life that could have caused that to happen again. You don't see them, do you?
11. Tim: Yeah, that's because what it was when I was poorly back in '06, I wanted to be in hospital because I wanted the help. When I was on heroin, yeah, I was on it for about, just about three and

a half weeks, and the majority of the time, I did have some, and when I went to hospital, I went to [hospital] because I went a bit mad in the head, and I got withdrawal symptoms for a couple of days, and after that, I was clean and I haven't touched it since then. So, I've been clean seven years of heroin plus like smoking, I stopped smoking as well, like, as you know about other drugs. Don't drink that much now, go to work, get out and about, and just keep well to my medication.

12. Housing support worker: He is.

13. Tim: So, I feel better now because this is where I wanted to be.

14. Chair: Well, you've actually achieved a very good recovery and you're sustaining it okay, and you're very, very mindful about what might trigger a relapse, which is obviously drugs and alcohol.

Tim responds to the chair's question by using extreme formulations (not at all, always paying bills on time, see Pomerantz, 1986), and thus offering reassurance that there are no worries regarding debts. The housing support worker *confirms* Tim's response and simultaneously produces a *positive assessment* of Tim's ability to take care of his financial matters by *adding* concrete evidence to it: "Brings me the receipt every two weeks" (turn 3). While applying these two devices, she displays herself as knowledgeable about Tim's money matters. After this, Tim starts recounting his experiences when he was living in another housing unit (turn 4). He presents his previous self as a victim of abuse, as "a lot of people" were continuously asking him to give them money and were pressuring him to do so. He was not even safe in the unit, since "people" could come to his door at any time. Notable in Tim's turn is that it contains the narrative of an identity change. He used to be a victim of 'financial abuse' in the past but is not anymore: "I've always got my money to myself now". This short turn can be interpreted as a recovery narrative: in terms of financial matters, he has moved towards living more independently. Right after Tim's narrative, the care coordinator and the housing support worker start talking almost at the same time. In their turns (5–7), they display knowledge of Tim's past as a victim and the changing situation in the current unit, and thus *confirm* the narrative. However, they also seem to slightly *challenge* the narrative by producing some concern and hint that the problem of Tim's inability "to say no to people" is perhaps not yet totally resolved.

Tim continues that the key to solving the problem is to get his “own place” (turn 8). It is difficult to interpret whether he disagrees with what the professionals have just said about the concern. Tim continues ‘change talk’, as he assures the professionals that he will not be involved with the ‘wrong kind’ of people anymore, especially if he gets support from the professionals and his family members. Admitting that he continues to need support, however, indicates that he remains in a recovery process. Here again, the housing support worker and the care coordinator join the conversation with *confirming* and *positive assessments* about the change that Tim has made in his life (turns 9 and 10). Furthermore, the care coordinator still *fishes* from Tim the assurance that he does not see certain ‘abusive’ people anymore (turn 10). Tim responds to this fishing not just by simply saying no, but by creating another recovery narrative, starting from the time when he still used drugs and ending with the situation where he stopped using heroin and smoking (turn 11). In the last sentence of this turn, Tim presents himself as a person whose governance of life is rather good in comparison with the past: “Don’t drink that much now, go to work, get out and about, and just keep well to my medication”. In turn 13, he makes a positive self-evaluation on this current state: “So I feel better now because this is where I wanted to be”. The housing support worker’s comment between Tim’s turns – “he is” – can be interpreted as *confirmation* of Tim’s talk on the positive changes (turn 12). Finally, after hearing the conversation between Tim, the housing support worker and the care coordinator, the chair concludes that Tim has “achieved a very good recovery”. He talks directly to Tim, thus showing that Tim is the main character in the recovery process.

To conclude, in this conversation about Tim’s history, he has epistemic authority. The chair poses his opening question directly to him and concludes the conversation by treating him as a core recipient. Tim is active in describing the processes of change in his recent history, thus displaying himself as an owner of this knowledge. The housing support worker and the care coordinator mostly confirm Tim’s talk and make positive assessments of the changes that Tim speaks about making in his life. While doing this,

they show themselves as partly knowledgeable about Tim's recent history, having access to it as professionals. This is predominantly an example of aligning and joint talk about the service user's recent history, with a slight note of non-aligned talk regarding whether the concern about letting 'abusive people' take Tim's money has been completely resolved.

'On behalf of talk' about the service user's recent support needs

Susan, the service user in the second extract, is a middle-aged woman who lives in a supported housing unit. Very early on in the CPA meeting, the chair asks Susan to outline the support she receives in the supported unit.

Extract 2

1. Chair: Can you tell us a little bit about what support you get?
2. Susan: They help us cleaning up in the flat. And they take us out places and that.
3. Chair: Yeah, okay, and how much help do you need?
4. Susan: How much help I need?
5. Chair: Yeah, some people need a little bit and some people need a lot. Where are you at?
6. Susan: I don't (..)
7. Chair: Okay, may I ask ((housing support worker)) about what her view is about how you manage?
8. Susan: Yeah.
9. Housing support worker: Susan has support from myself most days, and we've also now got a personal budget worker involved, and that's an extra nine hours a week.
10. Chair: On top of the support that you?
11. Housing support worker: On top of the support that she gets from myself and our support assistant. Susan's saying she's good at present, but in the last fortnight, Susan's been phoning the crisis team because your mood had dipped and you had thoughts of self-harm.
12. Susan: Yeah.
13. Housing support worker: And going to the shop and buying tablets. And when it was discussed you couldn't really say why, you just say it comes over you and it happens. But Susan, her life skills, if we don't see her daily, then it lapses, it really dips, and what we've done is we work off kind of timetables, Susan, don't we?
14. Susan: Yeah.
15. Housing support worker: We sit down and we have a plan of even when she eats because she forgets to eat.

16. Chair: Do you? Oh, right.
17. Housing support worker: So, we do menu planning. And we have pictures of breakfast and lunches just to give Susan ideas. We have a timetable for showering, cleaning and socialising. And Susan also has a daily journal where she writes down what she does daily, and this helps with her functioning.
18. Chair: Okay. It's quite highly structured, isn't it?
19. Susan: Yeah.
20. Chair: And how do you find that? Do you find it helpful or do you find it a bit intrusive?
21. Susan: Helpful.
22. Chair: You do okay. So, you welcome the support do you, okay? Without that support, what do you think you would do?
23. Susan: I don't know.
24. Chair: Would you do your cleaning up, would you do your washing, would you do your cooking?
25. Susan: Well, I'd do my washing, yeah.
26. Chair: Yeah, oh okay, but it's nice to have somebody around just like a little supporter really just to make sure things get done. What about paying your bills?
27. Susan: I pay them.
28. Chair: Yeah? Is that going okay?
29. Housing support worker: Susan is fantastic at paying her bills.
30. Chair: Are you? Right, okay.
31. Housing support worker: And brilliant with her medication and even brilliant with the washing; they're her three good skills.
32. Chair: So, you've got some skills that you're perfectly in charge of, haven't you really, but some that you need a bit of support on.

Susan associates “support” with “help” and replies that she gets help with cleaning and with going out (turn 2). The chair then reframes this by asking “how much help do you need?” which Susan simply repeats, demonstrating that she does not understand what is being asked (turns 3–4). Even though the chair re-phrases this by quantifying this as “a little” or “a lot”, Susan still does not provide an adequate response (turns 5–6). The chair, thus, asks Susan if it is okay for the housing support worker to give her perspective (turn 7). By asking permission for this, the chair recognises that turning to another person in this matter violates Susan's epistemic rights to assess her own everyday life and the help she needs in it. Susan's acceptance “yeah” (turn 8) gives the housing support worker a kind of permission to violate

Susan's epistemic rights. She also uses this right by answering the chair and producing information about the amount of support *on behalf* of Susan (turn 9).

The chair seems to question whether Susan is receiving extra support of nine hours per week through a 'personal budget' (turn 10). Recognising the inherent questioning, the housing support worker confirms by repeating the chair's phrase "on top of the support that" and continues with a justification. In doing so, she directly *challenges* a positive evaluation Susan made earlier in the meeting about her own situation, that "she's good at present". This challenge is produced by *adding* new knowledge as evidence: "Susan's saying she's good at present, but in the last fortnight, Susan's been phoning the crisis team because your mood had dipped and you had thoughts of self-harm" (turn 11). The first half of this statement is directed at the chair, referring to Susan in the third person, but it then moves to addressing Susan directly through "your" and "you had". By this direct addressing, the housing support worker invites Susan to confirm this knowledge, to which they both have access. Once Susan has affirmed this, the housing support worker continues by introducing further personal knowledge *on behalf* of the service user ("going to the shop and buying tablets", turn 13). Again, she starts by addressing Susan as "you", and then part way through the reply, she directs her answer to the chair, before again moving back to ask Susan a direct *fishing* question: "don't we?". Here, adding the tag question makes a positive yes answer conditionally relevant (Heritage, 2010), which Susan duly supplies. The use of rhetorical questions shepherds service users towards particular responses (Jingree et al, 2006).

In her following turns (15 and 17), the housing support worker provides the chair with extensive detailed knowledge relating to Susan's recent daily routines and life. The chair's reply is prefaced by the particle "Oh" (turn 16). "Oh" reveals that the chair finds the previous turn in some way problematic (Heritage, 1998), and she goes on to describe it as "highly structured" (turn 18). The *fishing* tag question, "isn't it?", again makes a yes answer preferable here, which Susan supplies. The chair then asks Susan, "Do you

find it helpful or do you find it a bit intrusive?” (turn 20). It is notable that the chair chooses Susan as the recipient in turns 16 and 18, which emphasises her epistemic rights in the matters under discussion concerning her personal life. Overall, questions are marked by ‘recipient-titled epistemic asymmetry’, but they also contain presuppositions and agendas (Hayano, 2014, p 400). In turn 18, the chair seems to imply that this highly structured timetable is rather controlling. However, Susan does not agree with this implication as she repeats the word “helpful”, which shows slight alignment with the housing support worker’s descriptions over the support that Susan needs in her everyday life (turn 21). In her next utterance, the chair asks a more general question (turn 22), which Susan is unable to answer (turn 23). Thus, the chair asks three specific questions related to cleaning up, washing and cooking (turn 24). Susan only answers one of the questions (turn 25); the “well” preface may indicate that she is contesting the answerability of the chair’s questions (Heritage, 2015).

The chair minimises the support that she previously alluded to as “intrusive” by describing it as: “just like a little supporter really, just to make sure things get done” (turn 26). Here, the chair is reframing the situation by decreasing the extent to which Susan is moving forwards with her recovery. She then asks Susan about paying her bills and gets a positive answer from her (turns 26 and 27). After that, she asks the housing support worker to endorse Susan’s answer that she pays them: “Is that going okay?” (turn 28). This checking positions the chair as doubting Susan’s answer, which, in turn, positions Susan as not having exclusive epistemic rights to knowledge of her own situation. The housing support worker *confirms* Susan’s answer and produces a *positive assessment*, stating, “Susan is fantastic at paying her bills” (turn 29). The chair again seems doubtful by again questioning Susan (turn 30). However, the housing support worker continues to display her knowledge of Susan’s everyday life by making a *positive assessment* of her other two skills: medication and washing (turn 31). This assessment leads the chair to conclude that Susan has some skills but needs “a bit of support” with others (turn 32).

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

To sum up, the conversation in this extract contains a lot of talk on Susan's behalf. The chair puts her first questions directly to Susan concerning the support she gets. Susan responds to the questions in a hesitant way, and soon, the chair asks her permission to turn to the housing support worker regarding her support. The housing support worker responds by producing a lot of detailed talk on Susan's behalf about the support she gets and needs. The chair directs a couple of questions to Susan, who gives short or hesitant answers. The housing support worker talks in a way that shows her to be very knowledgeable about Susan's recent history and personal everyday life. Susan does not resist this, but lets the housing support worker talk on her behalf. In this sense, the talk between Susan and the housing support worker is more joint than non-aligned,

'Disagreeing talk' about the service user's memory of services he is entitled to

The third extract is again taken from Tim's CPA meeting. The chair asks Tim about "117 Aftercare". Since this information is required on the CPA form, the extract demonstrates how the talk is structured around the completion of the form.

Extract 3

1. Chair: Are you aware that you're entitled to 117 Aftercare?
2. Tim: I've not heard of this before.
3. Chair: Most people haven't heard of it.
4. Care coordinator: We actually spoke about it last time, and Anna talked to you about it, about how certain things get paid for when you're on 117 because you'd been on a section of the Mental Health Act in the past.
5. Tim: Yeah, Section 3, yeah.
6. Care coordinator: Can you remember us talking, you can't remember us talking about that?
7. Tim: I can't honestly. I know you did, like I'm not saying you didn't, but I just can't remember.
8. Chair: We've got a leaflet there, but basically, it's one of the better things about being detained under the Mental Health Act.

It is notable that in her opening question, the chair makes an implicit assumption that Tim would understand her reference to the legal term “117 Aftercare”. As Tim’s care coordinator goes on to partly explain, the chair is referring to Section 117 of the Mental Health Act 1983 (turn 4).²

For the chair’s first question on his awareness of “117 Aftercare” Tim replies that he has not heard of it before (turn 2), which the chair confirms is quite common (turn 3). By normalising this unawareness, the chair saves Tim’s face (Goffman, 1967). However, after that, the care coordinator interjects and produces knowledge *on behalf* of Tim and *challenges* Tim’s knowledge (turn 4). The use of the word “actually” is significant, as Oh (2000, p 254) points out; it has a distinct function in talk, indicating that ‘the speaker is engaged in a particular speech act, especially of a face-threatening type, such as contradicting, correcting, or disagreeing with the previous speaker’. Further, Oh (2000) argues that the use of ‘actually’ signals unexpectedness and ‘tends to be associated with a denial of expectation, and thus often produces contrastive meaning’ (p 266). Here, the care coordinator is contradicting, correcting and disagreeing with Tim’s statement in asserting that she has spoken to him about “117 Aftercare”. This challenging of knowledge threatens Tim’s face in contrast with the chair’s talk; perhaps, Tim is not telling the truth, has a poor memory or is not interested enough in his own services. At the same time, the care coordinator saves her own face by displaying herself as a proper professional who has informed Tim about the service to which he is entitled.

Moreover, the care coordinator invokes an ‘independent witness’, Anna, to authorise her definition of the situation (Smith, 1978). Initially, Tim offers his agreement with only part of the assertion (turn 5). Thus, the care coordinator directly asks him if he can “remember us talking, you can’t remember us talking about that?” (turn 6). By repeating the word remember and the two-part format of the question (can you; you can’t), the care coordinator again presents the situation as having actually happened, positioning Tim as not recalling the conversation. Here, there is an implicit allusion made that the

problem is Tim's poor memory, aligning with his mental health service user identity. As the professional, the care coordinator holds the power of definitional privilege (Smith, 1978). In his reply, Tim does not dispute that the discussion has taken place and uses the word "honestly" which depicts it is a genuine loss of memory on his part (turn 7). Indeed, he explicitly states "I know you did" and adds "I'm not saying you didn't" showing his acquiescence with the care coordinator's version of events. The chair closes this sequence in a delicate way by not taking a stand on the disagreement and offering Tim further information on "117 Aftercare", thereby evaluating it in a positive manner (turn 8).

In summary, this short conversation is an example of disagreeing and non-aligned talk between Tim and his care coordinator. In the beginning of the extract, the chair treats Tim as the person to be asked questions about his own services. However, the conversation between the chair and Tim on services, especially on "117 Aftercare", is interrupted instantly, as the care coordinator challenges Tim's first response of not having heard of this particular section. The care coordinator displays herself as having better knowledge on this matter, which violates Tim's epistemic rights over his recent history. Although Tim claims or remembers otherwise, the professional presents "117 Aftercare" as having been discussed with him. Eventually, Tim admits that the care coordinator has better knowledge and he has a bad memory, but this happens only after the care coordinator's strong counterarguments towards Tim's own knowledge of the situation.

'Contradictory talk' about the service user's recent medication

The final extract is from Pete's CPA meeting. The extract is taken from the very start of the meeting where the chair asks an open question directed to Pete.

Extract 4

1. Chair: Okay, so today, did you have any particular questions to ask? Did you have anything in mind which you want specific help with?

2. Pete: ((sigh)) Is there anything you could give me so I could—I hate sleeping tablets, I don't like sleeping tablets. They're addictive and you can get very dependent on them. I hate tablets altogether. I only realised that a while ago. When I stopped taking drugs, I didn't go on anything. I just stopped taking everything all at once and that made me subconsciously hate taking drugs, any kind of drugs.
3. Care coordinator: Because ((Pete)) you're not prescribed anything at the minute, are you, and you haven't been for a while?
4. Pete: But I understand better than myself that I do need to be prescribed something because I can't go on like this most of the time
5. Care coordinator: Excuse me. The problem we had in the past is you weren't taking your medication
6. Pete: Yes, I know I wasn't, but I was taking my medication before I stopped. No, yeah, I was, when I was taking my medication, I was taking drugs as well. When I was taking drugs, I was on drugs; I was actually taking my medication regularly.
7. Care coordinator: Okay, well you weren't on
8. Pete: I know it doesn't change that fact. I know to the point of view where I'll sit at home and things will go on, and somebody will do that for me or somebody will do that for me, and I'll sit down. I can't stand it. It's horrible.
9. Care coordinator: Pete, can I just say, the time that you've had with the early intervention team and then you were handed over to me, there was lots of medi-packs full of medication, so you hadn't been taking it then.
10. Pete: No, I know I hadn't been taking them and I stopped taking them.
11. Care coordinator: Yeah, and then you haven't been taking them properly all the time I've worked with you and when ((housing support worker)) just (..)
12. Pete: But I was taking them.
13. Care coordinator: (..) tidied out your flat there was, she said, eight medi-packs hidden.
14. Pete: Eight, there wasn't eight. There were two.
15. Care coordinator: She has no reason to tell untruths.
16. Pete: Eight medi-packs? Boxes, no, there was two boxes of medi-packs.
17. Care coordinator: No, she said there were eight medi-packs full of medication hid behind the kickboards in the kitchen.
18. Pete: No, there wasn't, there was two of them.
19. Care coordinator: Well, she had no reason to (..)
20. Pete: Oh, I know what she means, there's eight packs of, yeah, I understand what she means by that. Yeah, I would agree on that because it was getting on my nerves because of the fact that she kept saying, 'your tablets are here, your tablets are there'. I had tablets from months ago hidden under there.
21. Care coordinator: It doesn't take away then the fact that you weren't taking them.
22. Pete: No, I wasn't taking them, but I didn't understand why I didn't want to take them, even though I know they were making me well. I'm not making excuses; yeah, I did hide them under there, and I didn't want to take my tablets.

The chair opens the meeting by giving Pete the right to choose what issues he wants to talk about, especially regarding help (turn 1). This underlines the importance of Pete's own knowledge of his support needs. Although Pete does not complete his reply to the original question, it is apparent from the turn that follows that he is requesting medication to help him sleep (turn 2). Pete emphasises how much he does not like sleeping tablets or, indeed, any medication by repeating the words "hate" three times in his reply. Thus, paradoxically, Pete has asked for something that he then states he does not want. The care coordinator starts her statement with a connective, which demonstrates her alignment; that is, Pete does not like medication and is not prescribed medication (turn 3). However, Pete then gives a dispreferred response, signalled by "but"; even though he has unequivocally stated that he "hates" medication, he now says that he does need to be prescribed "something" (turn 5). Here, the phrase "I understand better than myself" is interesting. Pete appears to position himself as being aware that although he hates medication, he recognises that he needs to be prescribed something. Here, Pete is implicitly attributing blame to the professionals in the meeting through the statement: "I do need to be prescribed something". In other words, the non-prescribing by the team is the reason he is not taking any medication.

Picking up on this, the care coordinator interjects to disagree and, thus, *challenges* Pete's own interpretation of his medication (turn 5). The care coordinator attributes the blame to Pete as an individual ("you weren't taking your medication") and identifies that this had been a "problem" for the team as a whole, not just her, in the past "we had". Once again, she is *challenging* Pete's own personal knowledge. In another apparently paradoxical reply, Pete initially agrees and then disagrees, signalled with the word "but" (turn 6). Although the care coordinator does not speak, Pete responds as if she has disagreed with him by stating "No, yeah I was". Hutchby and Wooffitt (1998, pp 212–213) write that 'it is not simply that people are trying to persuade their co-participants: they are also designing their talk in anticipation

of a sceptical or unsympathetic response'. Pete contends that when he was using illegal drugs, he was also taking his prescribed medication – a point he emphasises through repetition. Again, the word “actually” anticipates the care coordinator’s likely disagreement (Oh, 2000).

Once again, the care coordinator does not continue with overt disagreement and partially accepts what Pete has maintained before starting to make another point (turn 7); that this is another dispreferred response is marked by the word “well”, “Okay, well you weren’t on”. However, Pete interrupts her turn and accepts that she does have a valid argument, obliquely alluding to being a passive recipient of a service in his home (turn 8). This is an example of ‘indexicality’. Indexicality points to the ‘essential incompleteness’ of language (Garfinkel, 1967, p 29), as the meaning is intrinsically linked to the context in which it is said. The ‘transient circumstances of its use assure it a definiteness of sense . . . to someone who knows how to hear it’ (Garfinkel and Sacks, 1970, p 161). That the care coordinator knows how to hear it is demonstrated in her response, as she refers to the period of time when Pete was a client of the early intervention team (turn 9).

Rather than immediately disagreeing, the care coordinator gently prefaces her disagreement with the words “can I just say” (turn 9). Here, she evokes physical evidence – produces facts (Potter; 1996) – that Pete had not been taking his medication, i.e. the presence of “medi-packs” (pre-sorted containers for prescribed medication), which had not been taken. By doing so, she both *adds* knowledge on Pete’s personal knowledge and *talks on his behalf* by producing new knowledge on Pete’s recent personal history. Pete concedes that this was the case, although the word “stopped” implies that he had been taking the medication at one time (turn 10). After affirming his reply, the care coordinator then extends her argument from the period with the early intervention team to “all the time I’ve worked with you”, extending this to very recently when the housing support worker “just” tidied out his flat (turns 11 and 13). Although Pete interrupts to disagree, the care coordinator continues without a pause, using the

reported speech of the housing support worker to authorise her version (Smith, 1978; Juhila et al, 2014). Again, Pete implicitly accepts this, although disagrees about the amount of medi-packs that were hidden (turn 16).

Following this, the care coordinator strengthens her authorisation by again using the reported speech of the housing support worker and adding further details, which positions the worker as a direct observer, “hid behind the kickboards in the kitchen” (turn 17). Again, Pete implicitly accepts that the packs were hidden in this way, although continues to dispute the amount (turn 16). The professional’s account is also positioned as ‘uncontaminated by previous prompting or definitional work which might be interpreted as a form of bias’ (Smith, 1978, p 37) through the statement “she has no reason to tell untruths” (turn 15). Although Pete continues to dispute the number of packs, the combination of the care coordinator again using reported speech and starting to repeat that the worker had no reason to tell untruths (turn 19) leads him to accept this version of events, albeit maintaining that this is open to interpretation: “I know what she means . . . I understand what she means by that” (turn 20). Although accepting that the tablets were hidden, Pete puts the blame for this onto the worker, also using reported speech to invoke the worker as somewhat authoritarian “she kept saying, your tablets are here, your tablets are there”. The care coordinator does not enter into any disagreement about this matter but simply repeats that Pete was not taking the medication (turn 21), a point Pete reiterates, showing affiliation. He then overtly agrees: “yeah I did hide them under there, and I didn’t want to take my tablets” (turn 22). While the Care Coordinator does not explicitly acknowledge this agreement, this is reflected in the closure of this matter with a topic shift to the category of “sleep problems”.

Overall, this interaction can be described as contradictory, first in the sense that Pete asks for some medication to be prescribed for him, whilst at the same time, displaying a negative attitude towards taking tablets. It is also contradictory in another sense. The care coordinator and the chair do not comment on

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

Pete's wish to get some medication (even though a contradictory wish); instead, the care coordinator moves the discussion to focus on Pete's previous use of medication. She produces a lot of detailed knowledge about Pete's recent history related to medication, and in doing so, gives evidence of how Pete has not used the medication prescribed for him in the past. This is not totally non-aligned talk between Pete and the care coordinator, since Pete partly accepts the care coordinator's narrative on his earlier medication use. However, the strong role that the care coordinator takes in telling this narrative violates Pete's epistemic rights as the main narrator concerning his own recent history.

Discussion and conclusion

This chapter has examined who displays epistemic rights to the service users' recent personal histories in mental health CPA meetings. According to cultural understandings, people have primary access and ownership of knowledge concerning their personal lives and experiences. Therefore, in principle, access to this knowledge is asymmetrical: the service users can be assumed to have primary and more extensive experience-based access to knowledge regarding their own personal lives than the professionals; in other words, they have epistemic rights to this knowledge. However, in the CPA meetings, the housing support workers and the care coordinators displayed experience-based knowledge of the service users' recent situations at some points. This may be explained by the fact that the support workers are closely involved with the service users' everyday lives at the supported housing unit, and the care coordinators have regular contact with the service users related to their care plans.

The only ones 'not so knowledgeable' in the CPA meetings were the psychiatrists acting as chairs, who had no continuous everyday contact with the service users. They were more reliant on second-hand knowledge (see first position and second position assessments in Heritage and Raymond, 2005). It was

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

notable that the chairs treated the service users as primary owners of knowledge concerning their lives by clearly posing their questions first to the service users. Despite this ‘recipient design’, the housing support workers and the care coordinators often participated by answering the questions. As demonstrated in this chapter, this participation was accomplished by using six devices: confirming service users’ personal knowledge, adding some knowledge to service users’ personal knowledge, fishing for personal knowledge from service users, producing positive assessments of service users, producing knowledge on behalf of service users and challenging service users’ personal knowledge. By using these devices, the housing support workers and the care coordinators presented themselves as knowledgeable about the service users’ recent histories alongside the service users. Having access to this knowledge and displaying it in the CPA meetings can also be understood as pertaining to their professional duties; they are responsible for reporting in the meetings how the service users have recently been managing their lives.

In analysing the meetings, special attention was paid to whether the talk concerning the service users’ recent histories was joint or non-aligned between the service users and the professionals. Joint talk was prevalent, meaning that the professionals often just confirmed what the service users had just said, or they added some related knowledge and positive assessments on it. However, there was also non-aligned talk in the data. This tended to happen when there was a challenge; when the professionals challenged the service users’ knowledge or the service user challenged the professionals’ knowledge. At points where the professionals produced a lot of knowledge on the service users’ behalf or were fishing for particular knowledge from them, it was hard to interpret whether talk was joint, non-aligned or neither.

Whether talk about service users’ recent histories is joint or non-aligned between the professionals and the service users, an important question of epistemic justice still needs to be addressed. According to Fricker (2007), epistemic, especially testimonial, injustice occurs if speakers are not regarded as credible

storytellers, and their capacity to produce trustworthy knowledge is suspect (see also Lee et al, 2019, p 488). At worst, this kind of mistrust questions the human value and worth of a speaker (Fricker, 2007, p 130). It can be argued that epistemic testimonial injustice is strongly present if speakers' knowledge about their own personal histories is not taken as such, but instead, it is seen as something that needs to be confirmed or even challenged by someone else. Epistemic injustice is also obvious, if persons are disallowed from speaking on their own matters, and someone else speaks on their behalf without permission to do so. This kind of epistemic injustice can prevent the realisation of relational agency that takes service users as full participants in creating knowledge in multi-agency meetings (Edwards, 2011; see Chapter 2 in this book). It can also produce processes of shaming and turn the meetings into degradation ceremonies for service users (Garfinkel, 1956; see Chapter 3 in this book).

One of the conclusions of this study is that, occasionally, such epistemic injustice was present within the CPA meetings, where service users were not treated as trustworthy or able to tell and reflect on their own personal histories. This happened especially when the professionals challenged the service users' own interpretations of recent events. On occasion, challenging can have a professional justification, for example, if service users are defined as incapable of telling about their situation due to serious illnesses. This kind of challenging demands careful ethical consideration and, often, interactional skills that save service users' faces in a conflicting situation and prevent the meeting from turning into a degradation ceremony.

However, it is clear that the meetings also included examples of epistemic justice and signs of integration ceremonies, meaning equal collaboration between the professionals and the service users in knowledge production (see Chapters 2 and 3 in this book). It can be argued that the meetings' shared talk about the service users' recent histories and the professionals' and service users' joint access to them demonstrate a close relationship based on trust between these two parties. Co-telling a story to 'outsiders' in the

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

meetings strengthened the service users' voices, although the professionals have the ultimate power to make assessments of their situations.

Close analysis of the interactions in the CPA meetings presented in this chapter displayed aspects of talk that both enable and hamper service users' participation in such multi-agency meetings. It allows professionals to be aware of and reflect on the forms of language that enable service users' full participation in the care planning process. Hence, it also helps to achieve the policy-level aims of CPA that emphasise promoting social inclusion and recovery, and the principle of putting service users at the centre of the process.

References

Care Quality Commission (2016) *National Community Mental Health Survey*, London: Care Quality Commission.

Carpenter, J., Schneider, J., McNiven, F., Brandon, T., Stevens, R. and Wooff, D. (2004) 'Integration and targeting of community care for people with severe and enduring mental health problems: Users' experiences of the Care Programme Approach and Care Management', *British Journal of Social Work*, 34(3): 313–33.

Department of Health (1990) *Joint health and social services circular: The Care Programme Approach for people with a mental illness referred to specialist psychiatric services* (11 HC (90) 23/LASSL (90) 11), London: Department of Health.

Department of Health (1999) *Effective Care Coordination in Mental Health Services: Modernising the Care Programme Approach*, London: Department of Health.

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

Department of Health (2006) *Reviewing the Care Programme Approach: a consultation document*, London: Care Services Improvement Partnership, Department of Health.

Department of Health (2008) *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*, London: Department of Health.

Edwards, A. (2011) 'Building common knowledge at the boundaries between professional practices: Relational agency and relational expertise in systems of distributed expertise', *International Journal of Educational Research*, 50(1): 33–9.

Ekberg, K. and LeCouter, A. (2015) 'Clients' resistance to therapists' proposals: Managing epistemic and deontic status', *Journal of Pragmatics*, 90: 15–25.

Fricker, M. (2007) *Epistemic Injustice: Power and the Ethics of Knowing*, Oxford: Oxford University Press.

Garfinkel, H. (1956) 'Conditions of successful degradation ceremonies', *American Journal of Sociology*, 61(5): 420–4.

Garfinkel, H. (1967) *Studies in Ethnomethodology*, Englewood Cliffs, NJ: Prentice-Hall.

Garfinkel, H. and Sacks, H. (1970) 'On formal structures of practical actions', in J.C. McKinney and E.A. Tiryakian (eds) *Theoretical Sociology: Perspectives and Developments*, New York: Appleton-Century-Crofts, pp 338–66.

Goffman, E. (1967) 'On face-work: An analysis of ritual elements in social interaction', in E. Goffman: *Interaction Ritual*, Garden City, New York: Doubleday, pp 5–45.

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

Gould, D. (2013) *Service Users' Experiences of Recovery Under the 2008 Care Programme Approach*, London: National Survivor User Network and the Mental Health Foundation.

Hayano, K. (2012) 'Question design in conversation', in J. Sidnell and T. Stivers (eds) *The Handbook of Conversation Analysis*, Chichester, West Sussex: Blackwell Publishing Ltd, pp 395–414.

Heritage, J. (1998) 'Oh-prefaced responses to inquiry', *Language in Society*, 27(3): 291–334.

Heritage, J. (2010) 'Questioning in medicine', in A.F. Freed and S. Ehrlich (eds) *Why Do You Ask? The Function of Questions in Institutional Discourse*, Oxford: Oxford University Press, pp 42–68.

Heritage, J. (2012) 'Epistemics in action: Action formation and territories of knowledge', *Research on Language and Social Interaction*, 45(1): 1–29.

Heritage, J. (2015) 'Well-prefaced turns in English conversation: A conversation analytic perspective', *Journal of Pragmatics*, 88: 88–104.

Heritage, J. and Raymond, G. (2005) 'The terms of agreement: Indexing epistemic authority and subordination in talk-in-interaction', *Social Psychology Quarterly*, 68(1): 15–38.

Hutchby, I. and Wooffitt, R. (1998) *Conversation Analysis. Principles, Practices and Applications*, Cambridge: Polity Press.

Jingree, T., Finlay, W.M.L. and Antaki, C. (2006) 'Empowering words, disempowering actions: An analysis of interactions between staff members and people with learning disabilities in residents' meetings', *Journal of Intellectual Disability Research*, 50(3): 212–26.

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

Juhila, K., Jokinen, A. and Saario S. (2014) 'Reported speech', in C. Hall, K. Juhila, M. Matarese and van Nijnatten, C. (eds) *Analysing Social Work Communication: Discourse in Practice*, London: Routledge, pp 154–72.

Lee, E., Herschman, J. and Johnstone, M. (2019) 'How to convey social worker's understanding to clients in everyday interactions? Toward epistemic justice', *Social Work Education*, 38(4): 485–502.

Oh, S. (2000) 'Actually and in fact in American English: A data-based analysis', *English Language and Linguistics*, 4(2): 243–68.

Pomerantz, A. (1980) 'Telling my side: "Limiting access" as a "fishing device"', *Sociological Inquiry*, 50(3–4): 186–98.

Pomerantz, A. (1986) 'Extreme case formulations: A way of legitimizing claims', *Human Studies*, 9(2–3): 219–29.

Potter, J. (1996) *Representing Reality: Discourse, Rhetoric and Social Construction*, London: Sage.

Rautajoki, H. (2010) 'Tietämisoikeudet televisiokeskustelun vuorovaikutuksessa: Asiantuntijareviirit poliittisella areenalla', *Sosiologia*, 47(1): 24–40.

Raymond, G. and Heritage, J. (2006) 'The epistemics of social relations: Owning grandchildren', *Language in Society*, 35(5): 677–705.

Sacks, H. (1984) 'On doing "being ordinary"', in J. M. Atkinson and J. Heritage (eds.) *Structures of Social Action: Studies in Conversation Analysis*, London: Macmillan, pp 413–29.

Smith, D. (1978) 'K is mentally ill: The anatomy of a factual account', *Sociology*, 12(1): 23–53.

Interprofessional collaboration and service user participation

Negotiating epistemic rights to knowledge

Stevanovic, M. and Peräkylä, A. (2014) 'Three orders in the organisation of human action: On the interface between knowledge, power, and emotion in interaction and social relations', *Language in Society*, 43(2): 185–207.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J. and Le Boutillier, C. (2012) 'Social factors and recovery from mental health difficulties: A review of the evidence', *British Journal of Social Work*, 42(3): 443–460.

¹ Data derive from the research projects Responsibilisation of Service Users and Professionals in Mental Health Practices, funded by The Academy of Finland in 2011–2016. Following the ethical guidelines for social research in Finland and the UK, all participants were informed about the study in advance. At the beginning of the meetings, participants were briefly re-informed about the study and signed consent forms.

² Under this section, people who have been detained under certain sections of the Mental Health Act are entitled to free aftercare for services that have both of the following purposes: a) meeting a need arising from or related to the person's mental disorder, and b) reducing the risk of a deterioration of the person's mental condition.