ACCEPTING AND NEGOTIATING SERVICE USERS' CHOICES IN MENTAL HEALTH TRANSITION MEETINGS

Abstract

Across Western welfare regimes, policies emphasize that service users should have more choices regarding their services. This article examines how service choices are presented, responded to and decided in interactions between service users and professionals in mental health transition meetings. Choice is often associated with consumerist user involvement ideas, but in mental health choice also relates to democratic user involvement approach and to shared decision making between professionals and service users. The results of the study show that professionals construct service users as consumers by offering service options in choice making sequences, expecting users to make appropriate choices. Service users mostly act like consumers by responding to these choice options. However, the study also demonstrates that the professionals do not always accept the user' first choice but respond to them as non-preferred. Sometimes they also suggest choices on behalf of the users. In these 'non-accepting' sequences choices are negotiated in interaction between the parties, rather than users acting as autonomous choice makers. The sequences are based on two kinds of professional reasoning: first the professional-led needs assessment and second the structure of the service package that the user is being offered. This negotiation has elements of shared decision making and the 'logic of care'. But it also has elements of paternalist control which

challenge both consumerist and democratic service user involvement and suggests consideration of more collectively oriented service user actions.

Introduction

User choice discourses which reflect consumerism and user involvement have been dominant in Western welfare states in recent decades (Ferguson 2007; Greve 2009). They are grounded in a general ideological shift away from welfare dependency and professional control towards more active service user roles with associated rights and responsibilities. Users should have more autonomy and control over their lives, including possibilities to make choices regarding the services they receive. However, as Antaki et al. (2008: 1165) put it, allowing and encouraging choices may be easier when formulated at the level of policy recommendations than when implemented in everyday institutional practices.

In this article we examine how service choices are presented, responded to and decided at the micro-level, in meetings between service users and professionals regarding mental health supported housing. The data comprise mental health transition meetings, where plans are made and choices offered about the content, timing and frequency of floating support services. Floating support involves regular visits to service users in their own home as an alternative to supported housing units or residential care. Before presenting the research

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setting, the data and its analysis, we examine user choice and involvement in the social policy and mental health literature relevant to the supported housing context.

User choice and user involvement approaches

User choice is often linked to notions of consumerism in public services, which claim that services users' own preferences instead of expert-defined needs should be the first priority in providing services (Needham 2009: 79). Service users as consumers are seen as individual rational actors, who know what they need, make decisions that maximize their preferences (Fotaki 2009: 88) and 'express their views about services via complaints and feedback systems' (Barnes 2009: 231). Such approaches draw on rational choice theories (e.g. Le Grand 2007), which claim that people make decisions in their own interests by comparing the benefits and costs of existing choices (Greener 2007: 260). Consumerism has gained support in mental health, where it is argued that service users are able to act as individual, rational and responsible choice makers regarding their own affairs (Hickey and Kipping 1998; Tsemberis 2010). According to Beresford (2002: 96-98) and Pilgrim (2009: 86-89) the consumerist approach represents conservative and managerialist service user involvement models, which recognizes users as providing valuable service feedback, thereby making service provision more effective and profitable.

Researchers have, however, raised concerns about consumerism. It has been questioned if there are always real options available including the possibility to exit from unsatisfactory services, and if there is enough information for service users to make informed choices

(Greve 2009: 543-547; Greener and Mannion 2009: 96). There are also concerns that consumerism entrenches rather than reduces pre-existing inequities, for instance whether users have equal possibilities to gain access to information about service options (Fotaki 2009: 91). A serious criticism directed at the premise of consumerism is the extent to which service users act as rational calculative actors. Rose (2000; Miller and Rose 2008) connects this development to the discourse of responsibilization, in which citizens are expected to become 'enterprising selves', who manage and empower themselves and thus produce their own independency and well-being (cf. Clarke 2005; Teghtsoonian 2009; Author1). Along with increased possibilities to make choices, service users also carry the risks of making bad choices (Silverstein and Spark 2007; Kemshall 2008). Furthermore, rational choice making has been criticized for ignoring the fact that people invariably make choices in relation to other people, to certain embodied practices and settings and to certain power relations (Niemi 2011: 23). Accordingly, all choices whether they are regarded as right or wrong, preferred or non-preferred are the product of relations accomplished in certain contexts.

Such criticisms of consumerism need to be taken seriously in mental health. Innovations which promote consumerism, like personal budgets and personalised services, have been slow to develop in mental health (Valsraj and Gardner 2007: 63). Service users are usually not in a position to choose, for instance, which organization provides their services. They can refuse a service or exit from their present service. However, such refusals might compromise any offer of what they consider more appropriate services, as it might be treated as a symptom of their condition. Service users often lack information about complicated service systems

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and the options available to them. Choice in mental health concerns 'complex and highly individualized services' (Valsraj and Gardner 2007: 61), including various relational 'situations of choice' (Mol 2008: 8), which makes a rigid consumerist approach inappropriate. In the end, consumerism cannot, as Barnes (2009: 231) argues, 'encompass the depth and diversity of means through which people who use health and social care services seek to influence the social relations of welfare'.

Even though the consumerist approach has been criticized, a right to make choices is not questioned per se. Glendinning (2008: 459-461) writes that there are strong arguments for emphasizing user choice. It can be fundamental to achieving citizenship, social inclusion and independence. It can reduce power differences between care providers and receivers, and the capacity to exercise choice and control over one's life can be an important care outcome itself. These kinds of arguments are familiar in what Beresford (2002) calls a democratic service user involvement approach, 'often framed in a rights discourse' (Noorani 2013: 50). The democratic approach accomplished through collective user movement actions underlines people's self-advocacy and participation in having more say in their own lives, services and society (Beresford 2002: 97). Choice offers opportunities to choose and plan one's own services in a given service frame or to respond to official health and social care initiatives to evaluate and give feedback about available services. It also offers opportunities for citizens who have experience of using social and health care services (as 'experts-by-experience') to voice their perspectives on service options and their contents and on more general issues of

personal and social life (Barnes and Cotterel 2012a: xx-xxi). The orientation is then towards 'wants' rather than 'service needs' (Floresch 2002: 81).

In everyday mental health practices, choice and user involvement are realized both at the collective, macro-level of planning, evaluating and developing services, and at the micro-level where choices and decisions are made about service users' package of care (Tait and Lester 2005: 169; Weinstein 2010). At the latter level, and especially in the interaction between users and professionals (which this study examines), involvement has been suggested as being realized in shared decision making processes (Schauer et al. 2007; Edwards and Elwyn 2009; Simmons, Hetrick and Jorm 2010; Matthias et al. 2012). Shared decision making is often contrasted with autonomous (cf. consumerist) and paternalist, professional-led decision making styles. Matthias et al. (2012: 306) summarize the characteristics of shared decision making: it is 'an interactive process between at least two parties (patient and provider) in which sharing information occurs, patients preferences and providers responsibilities are discussed, and both parties agree on a course of action'. Hence, service users are not seen as making service choices individually, but in reciprocal interactional processes with providers and professionals. The extent to which this reciprocity includes elements of democratic user involvement is an important question which we also address in this study.

Studying choices in interactions between service users and professionals

User choice has been examined at a policy level, mostly as a welfare state ideology connected to welfare consumerism, welfare markets, and neo liberalist ideas and to New Public Management (e.g. Blomqvist 2004; Glendinning 2008; Blank 2009). Its implementation in procedures like direct payments, personal budgets and service vouchers, has been studied (e.g. Ferguson 2007; Glendinning 2008; Willberforce et al. 2011). There are also studies concentrating on service users' experiences, opinions and attitudes about their choice making possibilities, shared decision making processes, and whether they regard choice making between competing services as effective and desirable (e.g. Adams, Drake and Wolford 2007; Eichler and Pfau-Effinger 2009; Fotaki 2009; Greener and Mannion 2009; Woltman and Whitley 2010; Peckham et al. 2012). The common methods of data collection in these user studies are interviews and questionnaires.

What has been examined less is how choices are actually presented and responded to in everyday micro-level institutional practices (Antaki et al. 2008: 1166). For instance, there is a lack of research concerning, whether and how service users are enabled to behave like consumers in choice making situations (Fotaki 2009: 88). Do professionals take a paternalist orientation, or does choice making as a shared process include the possibility of democratic user involvement? This is a serious gap in the literature, since choices concerning individual services are inevitably accomplished locally in interactions between professionals and users within particular institutional contexts (Greener 2007, 263; Greener and Mannion 2009: 100).

This study concentrates on everyday professional–user interactions, where choices concerning available service provision are routinely offered and negotiated. Studying

everyday interactions can shed light on questions such as how service users describe their wants, needs and preferred choices; how these service user voices are heard and responded to by professionals; how available services are presented and recommended, and the resulting service provision which emerges. Discourse and conversation analyses basing on ethnomethodology provides tools for examining these kinds of everyday interactions in institutions (Heritage 1997; Silverman 1997; Hall et al. 2014).

Mental health and housing support services as a research setting

People with mental illness are often at risk of losing their housing and thus in need of housing support services. The current approach to the organization of such services is to separate housing and support elements, so that difficulties in one area do not undermine the other. This is emphasized, for instance, in the Housing First model (HF-model) (Tsemberis 2010), which has become highly influential in some European countries in recent years, including Finland where this study is situated (Tainio and Fredriksson 2009; Pleace 2011: 118). In this model housing is seen as a basic human right, as well as a right of service users to have a consumer choice in the services they receive (Hansen Löfstrand and Juhila 2012).

HF-model is consistent with the processes of dehospitalization in Western societies over recent decades. In mental health this has meant services provided less in hospitals and nursing homes and more in the community and the home. A key argument, strongly supported by collective service user movements, has been that instead of treating mental health service users as dependent people needing paternalist care, they should be seen as independent

citizens, having a right to live in normal communities and houses, and able to make choices of their own. The Finnish government plan on mental health and substance abuse services supports this development by emphasizing both consumerist and democratic user participation, aiming to create services that are more user-led, responsive and based on users' own expressed wants and 'experts-by-experience' knowledge (Ministry of Social Affairs and Health 2009).

Our research setting, a Floating Support Service (FSS) for people with mental health problems, has similarities with the HF-model. Housing and support services offered by the FSS have been separated. The declared principles of the project include respecting service users' choices, self-determination and individual recovery processes. Floating support also represents the latest development in the Finnish mental health policies, enabling a shift towards more community based and user-led services.

The FSS is managed by a large mental health organization (NGO), under a contract from the local municipality. The NGO was founded in 1970s to offer user-led and community based services as an alternative to hospital treatment. Users can apply to the service directly, or they may be referred by their doctors or other professionals. The latter route is more common, meaning that in addition to the users, several professionals from different organizations have a stake in identifying an appropriate service. The final formal decision to agree a placement is made by the representative of the service purchasing municipality, but s/he participates in the choice making processes with the users and the appropriate professionals before making

the final decision. Hence, the processes are interactive and might in this sense include elements of shared decision making.

The 10 professionals employed in the FSS are qualified mental health workers and work with about 60 service users. The aim is to support and increase their capacities to live independently. The main activities are home visits by professionals to the service users' home, including discussions and advice giving based on the service users' needs and wishes. The visits focus on everyday skills (like housework, cooking and taking care of personal money matters), social skills, monitoring medication compliance, learning to recognize one's own illness and its symptoms, avoiding social isolation and living a meaningful life. Another important method of working is networking. This means mapping the meaningful networks – institutional and professional actors as well as informal actors like family members and friends – of each service user and using them as resources in recovery processes.

Data and analysis

The study draws on a larger research project which examines everyday mental health practices, conducted in three supported housing and floating support services in Finland including the FSS. The fieldwork was carried out during 2011 and 2012 and resulted rich research material, including interviews with the service users and the professionals, documentary data and audio-recordings of various meetings and home visits. The fieldwork was started in each service with the researchers' visits, where the research was presented and discussed with the users and the professionals. Information sheets of the research were

available in all settings during the fieldwork. Participation in the research was voluntary and those who agreed to participate signed consent forms. The research ethics committee of the university, where the research is based on, gave an approval statement in 2011. The steering group of the research included both service user and professional members. The findings of the research and its implications have been and will be discussed in various forums including professional teams and service user groups.

The data corpus of this study consists of around 30 audio recordings of meetings between services users and professionals. For this paper we analyse in detail four transition meetings. These meetings are particularly important as they involve a major step in the service users' pathway to independence, so balancing the service users' needs and wants is particularly important. These service users (all male) have already been proposed by the municipality as potential clients of the FSS, and are currently attending a short term residential Assessment and Rehabilitation Course (AR). Clienthood in the 'old' organization is just about to end and the new clienthood in the FSS will probably begin soon. The users had indicated a preliminary interest in accepting the services offered by the FSS. So, the meeting represents a particular phase of the path to the FSS, where various stakeholders are involved in choice making.

At least four persons are present in each transition meeting: the service user, his keyworker(s) from the AR, and two professionals from the FSS. One of the FSS professionals leads the meetings by asking questions concerning what the client wishes to gain from the service. Since clienthood in the FSS is expected to begin soon, the service choices under discussion

deal with 'what' (the content of professional support and help) and 'when' (the frequency and timing of when are services provided) questions, rather than with 'where' and 'who' questions (which service providers, which professionals) (Le Grand 2007).

The meetings proceed on the basis of a six page transition meeting form, which includes questions about health condition, medication, self-knowledge, substance use, financial matters, and assessment about service users' support and service needs. The questions are mostly open, but there are also some tick box choices. The form is written in a 'you-format' with the questions directly addressing the service user, for example, 'what kind of help/support do you wish from the FSS?' The meeting is structured around the topics on the form. It directs the FSS professionals to ask about the user's present condition and situation (first task) and to plan the elements of the FSS intervention (second task). The second task and the associated questions on the form are the core topic of this paper, since they deal with choices about the content, frequency and timing of the services. This part of the form clearly invites choice talk. The meetings proceed in an interview format (Silverman 1997), following the order of questions on the form. The FSS professionals pose the questions and write down answers on the form. Although the questions are directed at the service users, every now and then the AR's keyworkers join in to provide answers with or on behalf of the users.

All four transition meetings are rich in choice talk, although there is some variation in frequency. We located 80 interactional sequences, where choices related to services are discussed, all of which are initiated by one of the FSS professionals. The professionals present choices in the majority of cases as limited options: the services users can either make

a choice whether they want or do not want a suggested service, support or help, or they are offered alternative restricted options. But there are also sequences, where choices are presented as open without prescribed options.

When it comes to choice making (decisions) in the majority of the sequences (59/80) the professionals accept the service users' first choices. In 21 sequences the professionals questioned the first choices and/or negotiate choice proposals. There were also occasions where the service user was uncertain about making choices, usually followed by the professionals' advice or persuasion to make the choice. In rare cases the negotiation starts when the keyworker makes the first choice on the behalf of the service user (see the Table). First choices are accepted more than negotiated in all the meetings, but the proportion of negotiating sequences is somewhat higher in one, where the keyworker (AR) displayed a more active role.

Table: Choice making sequences in transition meetings

Choice making sequences in total	80
A. Service users' first choices are accepted (Extracts 1,2 and 3)	59
B. Choices are negotiated 1. User makes a choice – professional questions it (Extract 4) 2. User makes a proposal to open choice initiation – professional questions the proposal (Extract 5) 3. User shows uncertainty in limited choice situation - professional gives advice and persuades (Extract 6)	21

4. User's keyworker makes the first choice – user agrees with the choice (Extract 7)	

In this paper our primary interest is on those sequences where choices are negotiated in four different ways (the box B in the Table). We concentrate on these sequences, because they do not seem to match to user choice approaches, particularly consumerism, as the service users' first choices and wants are not accepted and/or are negotiated. However, in order to understand these sequences, it is necessary to start by examining the sequences where service users' first choices are accepted, where there seems to be no problems in acting in accord with the users' wants (the Box A in the Table).

In analysing the data we apply discursive methods to interaction analysis (Hall et al. 2014), especially conversation analytic notions about sequentiality, focusing on the professionals' and the service users' ordered actions in choice making sequences (Heritage 1997):

1) Who starts the choice sequence and how (the initiatory act)?

2) Who makes responses and how (the responsive act)?

3) What kinds of services users' responses (choices) are treated as preferred or non-preferred and how?

By concentrating on these three questions, we make visible how choices are displayed in interaction and what influences negotiations have regarding the content, the frequency and timing of the services in the FSS.

Service users' first choices are accepted

Our first three extracts are choice making sequences where the service users' first choices are *accepted* and thus assessed as *preferred.* They represent different types of choice options for the users, both what (the content of service) and when (when services will be delivered and how often) situations. The first is an example of 'yes or no' closed question (needing or not needing support) (Antaki et al. 2008). See the transcription symbols in the note 1.

  Extract 1: Presenting 'yes or no' options and accepting the first choice

  FS: Then regarding money matters it is asked ((refers to the form)) not in a way

     that we should know them as such but if you need help for some social support

     matters or [applications?

  SU: [Yes I need

  FS: So in general do you need help in taking care of money matters?

  SU: I need I need help for Social Services' matters.

  FS: Yeah.

The professional from Floating Support (FS) initiates this sequence. Her question is based on the form which is strictly followed and explicitly referenced ('then regarding money matters it is asked'). The question is targeted at the service user by inviting him to make a choice; whether or not he needs support in money matters. The service user accepts the invitation. He makes a choice immediately (overlapping talk) and without hesitation – he

needs help in money matters. After that the professional still repeats the user's choice in the form of a question and the user confirms his choice with the double emphasis: 'I need I need help…'. The professional closes the sequence with minimal acknowledgement. The service user's first choice is accepted and is assessed as a preferred response.

The second extract displays a question that offers limited options to make a choice, concerning the content of the service (what).

Extract 2: Presenting limited options and accepting the first choice

FS: So who would you like do you have anyone in your close network who would you like to support your rehabilitation in home?

        (1)

SU: Well probably mum.

        (3)

FS: So she wou- for instance she would come that it is <u>you yourself who decides</u> that we don't decide on behalf of you, that if you want so she could come then sometimes to this kind of meeting<u>.</u>

SU: Yes she certainly likes to come.

FS: Yes.

The professional's initiatory question invites the service user to express his own preferences regarding informal support in rehabilitation process. This question is based on that part of

the meeting form where the aim is to map possible available rehabilitation resources. When posing such a question, the professional limits the choice making options: it is suggested the user choose someone from his 'close network', not anyone outside it. The user accepts this limited choice and makes his selection accordingly, although with some uncertainty, 'probably mum'. This hesitant response is followed by a long pause and after that comes the professional's long turn. It starts by echoing the user's choice but simultaneously shows some uncertainty toward the choice (repetition, interrupted sentence, conditional form). After the hesitancy the professional emphasizes that the service user is an independent decision maker who makes his own choices. The professional provides an indirect question, stressing again the user's own wishes, whether he (really) wants his mother to participate to the (case conference) meetings. In his response the service user talks on the behalf of the mother, who 'certainly likes to come'. When saying this, the user does not indicate uncertainty or discomfort with this choice. The professional accepts this second response and thus also the service user's first choice.

Our last 'choice accepted' sequence provides an example where the professionals present open questions and thus also open options for the users (cf. Antaki et al. 2008). Choices are made about the timing of the service (when-choice).

Extract 3: Presenting open options and accepting the first choice

FS: What do you think about how often should we make visits to your home?

SU: I think that three times a week for a start.

FS: Okay. (3) ((writing))

FS: And what days and times of day could they be?

SU: Well let's say on Monday (1) Wednesday and (1) Thursday.

FS: Okay (.) we now receive your wishes, our places begin to be quite full but we listen to your wishes. So what time of day would it be for you?

SU: Well at six pm would probably be rather good, between six and eight.

FS: Yeah.

Again the professional's initiatory question is based on the form, inviting the service user to make a choice about the frequency of the home visits. The choice options are open in the sense that the question does not include any suggestions concerning the possible frequency. The user's response is a choice making act; his preferred amount of visits is three times a week at least in the beginning. This response is treated as preferred by the professional, since she acknowledges it immediately and writes it into the form. There follows another open question regarding the preferred weekdays and times for visits. The user's response reflects flexibility about the weekdays. The professional accepts in principle this flexible choice, but also indicates possible limits in fulfilling the users' choices because of (staff) resources. After that follows a third open choice question concerning the visiting times. Again the professional accepts the first choice made by the user.

Choices are negotiated

The next four choice making sequences differ from those above. Either the service users' first choices are not accepted but are treated as non-preferred, or the users are uncertain or do not make a first choice at all. In all these cases choices are negotiated between the professionals and the service users so that the professionals' actions significantly influence the final choice selection.

In the next sequence one of the professionals questions the user's first choice regarding the content of the service in the FSS:

Extract 4: User makes a choice – professional questions it

FS: You take care of money matters yourself?

SU: Yes.

FS: Do you need help in taking care of those money matters?

SU: I don't think so, that I have quite (normally after I) went to hospital so I have taken care of them myself.

FS: Okay.

AR: Well you need Jaakko some help [really.

SU: [Do I need?

AR: Yes.

SU: Oh.

AR: So well when it is a case of income supports and such.

FS: Yes.

AR: And well there are some arrears from the last summer but which Jaakko has
        started <u>paying back appropriately.</u>

FS: Mm.

AR: But so that (1) and sometimes every now and then somebody could look at with
        you those bank statements [and

SU: [Yeah

AR: and what is the situation but mainly [there hasn't really been [such such
        problems.

FS: [Yeah   [okay.

This choice making sequence starts with a pre-sequence, where the professional puts a

background question about the user's money matters. The question implies that the service

user carries responsibility for his own finances. With a 'yes' response the user confirms this

implication. The next question (based again on the form, cf. Extract 1) invites the user to

make a choice as to whether he needs help with taking care of his money matters. Following

logically from the pre-sequence, the user considers that he does not need this kind of help,

indicating that he has independently been taken care of his finances for some time. The

professional accepts this response and her 'yeah' turn could be read as closing this sequence.

However the professional from the AR, who has been acting as the user's keyworker for the

last three months, interrupts the choice making sequence. In her turn she questions the user's

choice by directing her words to the user: 'well you need Jaakko some help really'. This

challenge produces the user's first choice as non-preferred and needing reassessment.

The user's response to this intervention displays surprise, possible non-agreement and a request for clarification of the keyworker's assessment: 'Do I need?' This is a delicate situation: how to proceed when the choice made by the user and FS is challenged. AR shows that she recognizes the delicate situation by justifying her opposing assessment, based on her past knowledge about the user's situation. As a keyworker she and the user have access to this knowledge unavailable to FS. She now directs her talk to FS, starting to talk about Jaakko in the third person. On the basis of this inside knowledge AR makes a prediction for the future: although the user has progressed in taking care of his money matters, he still needs some help with them. The user's minimal responses 'yeah' and 'okay' display not overt, but perhaps passive resistance toward this assessment (Juhila, Caswell and Raitakari 2014). Resistance might have been mitigated by AR's face-saving acts: she limits the help offered to 'every now and then' and emphases that the user nowadays takes better care of his money matters. To sum up, in this choice making sequence, the user's first choice (not needing help in money matters) is treated as non-preferred, is rejected and a new 'choice' is delicately negotiated (needs help in money matters).

In the next sequence the service user presents his first choice concerning the frequency and timing of home visits in the form of a proposal. The professionals do not accept the first choice, but reformulate it.

Extract 5: User makes a proposal to open choice initiation – professionals question the proposal

FS1:   And then what is your estimate about that that how many days in a week we would visit your home (2) at least in the beginning?

SU: Well could it be once a week?

FS2:   That is rather <u>little.</u>

FS1:   They can be at first even more, they can then be reduced to that once a week and if they have a possibility to visit also later when you have spent a day in a Workshop ((refers to a supported work place)) so that

FS2:   That we don't.

SU: Is it then, how will it then be done, that is it then one day so that when I go to the Workshop, or can they visit always in evenings?

FS2:   So our visiting days are from Mondays to Saturdays ((describes their working hours)) and then about half past seven or at eight o'clock we have finished the last visits, so that between these ((weekdays and times)) it has been possible to fit a visit, it can be absolutely reduce to one ((visit)) later
        [but that

SU: [Would [twice then be better?

FS2:   [Yes twice or three times at least I would say here [beginning.

SU: [Okay.

FS2:   Because moving is also stressful even though it is a wonderful thing it causes stress to everyone, it always comes something to mind and before one gets used to a new home, that you find everything and

SU: Yes (3) well whatever twice or three times.

This choice making sequence concentrates on when-choices related to the frequency and timing of home visits (cf. Extract 3). In the first question FS1 asks the service user how often the home visits could be done and invites the user to make a choice. The user responses with a suggestive question: 'well could it be once a week?' FS2 marks this suggestion as non-preferred, when she assesses once a week visit as 'rather little'. This direct disagreement with the user's proposal is instantly softened by FS2's turn, demonstrating that challenging the user's own choice is a delicate matter (van Nijnatten and Suoninen 2014). The 'softening turn' includes both a new proposal ('they can be at first even more') and a reformulation of the user's proposal ('they can then be reduced to that once a week'). FS1 continues the softening when she describes the flexibility of timing of the home visits: they can be also done in an evening. The FS2's turn initiation ('that we don't') seems to continue this softening talk.

In response the user takes an active 'consumer role' by asking whether the visits could always be done in evenings, hinting that this would be his preference and choice. FS2 displays acceptance of this preference by describing FSS's routines and visiting times, including a possibility to organize visits regularly in evenings. Then she repeats the prospect that the visit frequency can be reduced later, hence indicating the user's first choice is thus not totally rejected but has been heard and respected. The user interrupts the professional's turn and makes a new proposal, 'would twice then be better?' FS2 marks immediately this choice as preferable to the first one, but adds that three times would be better. The user responses with 'yeah'. FS2 appears to interpret the minimal response as possible resistance, since she further continues accounting and justifying why more frequent visiting would be important in the

beginning. The user does not disagree with this reasoning, but closes the sequence by announcing that both twice or three times a week are acceptable for him. However, 'whatever' can be heard as closing the discussion without wanting to indicate agreement.

In the sixth extract the service user shows uncertainty in choosing a support person for himself from his close network. The professional responds by giving advice and persuading.

Extract 6: User shows uncertainty in limited choice situation – professional gives advice and persuades

FS: And then here is still the question ((refers to the form)) that who from your <u>close network</u> would you like to support your rehabilitation?

SU: I can't can't really say anything to that that I have those people in the Support Centre that I get along well with the counsellors and the people there, that I don't know whether it is necessary to have more if you also start (1) visiting me at my home, so I don't don't really find out anything for that.

FS: But would it be good to have sometimes common meetings with the Support Centre's workers. I noticed that you have had such with the Course's workers too. So could it be thought such ((meetings)) where your parents also could come? This is also very much like our way of working that we have these kinds of network meetings because it is the best way of getting and sharing information when all the stakeholders are present (1). Is that fine with you?

SU: Yeah.

FS: I put here that co-operation with the Support Centre and probably with the family
        as well?

SU: Yeah.

FS poses a form based question to the service user about his preferences: 'Who from your
close network would you like to support your rehabilitation?' (cf. Extract 2). In his response
the user shows uncertainty in the sense that he says that he cannot give an answer to the
question. He justifies this non-preferred 'not choosing anyone' choice by listing the people
that are already available to support his rehabilitation. He states clearly his own preference
of not needing more supporting people.

The professional marks this reasoning and choice as non-preferred. She begins her turn with
'but', followed by a proposal: 'Would it be good to have sometimes common meetings…'.
FS accounts and justifies this view by invoking 'our way of working'. These kinds of
meetings are common institutional routines in FSS. This meeting and its benefits are then
explained to the user, and an expectation to name someone from the close network. After
such persuasion, the professional makes a closed yes or no question: 'is that fine with you?'
with a clear anticipation of yes answer. The user's answer is 'yeah' which can be read as
passive resistance more than clear acceptance. However, the professional makes a follow-up
question to ensure the user's 'second' choice: 'I put here that co-operation with the Support
Centre and probably with the family as well?' The user responds again with 'yeah', which
closes the choice making sequence. The choice is then documented on the form.

The last sequence is an extreme choice making situation in the sense that the professional takes a leading role in formulating the first choice related to the need of support or help.

Extract 7: User's keyworker makes the first choice – user agrees with the choice

FS: How about for anxiety and tension?

        (2)

AR: Social situations strange people think about them Eero.

SU: Yes that might be it ((refers to the need of support)).

FS: Yes.

FS invites the service user to make a choice regarding support related to possible anxiety and tension. The service user does not take up this invitation to express a preference on this matter. Instead there is a two seconds pause. AR (the keyworker) breaks the silence and poses an indirect follow-up question for the user. The turn hints at the preferred choice: 'social situations strange people think about them Eero'. As in the Extract 4, the keyworker uses her previous knowledge about the user as a resource when indicating that Eero might need support in order to manage better in social situations in future. In her turn AR persuades the user to join this interpretation based on their common experiences: 'think about them Eero'. Persuasion is successful and the user accepts the choice initially made indirectly by AR. FS closes the sequence by confirming the 'help and support is needed' choice.

Conclusion and discussion

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In this article we have analysed how, what and when service choices are presented, responded to and made in the mental health transition meetings. Our results show how principles of consumerism are implemented in professional-user interaction as the professionals offer service options (initiate choice making sequences) for users to respond to as rational decision makers. The transition meeting form designed for interviewing users directs the professional-user interactions to be treated as 'choice talk', as the professionals initiate exchanges with the user in terms of the form's service choice questions. The service users for their part also act like consumers by responding to the choice-questions, sometimes with certain and sometimes with uncertain responses. In the majority of the choice making sequences, the professionals accept and respect the service users' first choices, even though they might raise questions or present some institutional constraints related to the choices (see Extracts 1-3).

However, the transition meeting form structures what kinds of service choices the professionals are able to present in the meetings. The form, and accordingly the meeting talk, contains several closed 'yes or no' questions as well as questions with limited options. Hence, the service users are not free to choose any service, instead they have to make their choices from the form's 'service menu'. In addition choices are limited in other ways during the course of the meetings. These limitations appear in the choice making sequences, where the professionals do not accept the users' first service choices but respond to them as non-preferred (see Extracts 4-7). Marking choices as non-preferred is based on two kinds of reasoning: the professional-led needs assessment and the available service package that the FSS has designed for the users.

The professional-led needs assessment comes into play especially when the AR professionals who have been working with the users, become involved in the interaction. The transition meetings are unusual encounters which are set up as dyads between the FSS professionals and the service users, but enabling the possibility of an interruption from the AR professionals. Presumably if the AR professionals consider there are no uncertainties with the users' first choices, they do not become involved. When they do intervene, they display themselves as more knowledgeable about the users' needs than the users, whom they consider do not identify their particular needs (see Extract 4). The AR professionals can also propose what to choose, if the users are uncertain about making choices or do not make choices at all (see Extract 7). It can be argued that there are elements of paternal decision making in this kind of professional-led discussion.

The prescribed nature of the FSS package is displayed in a number of ways. In conversations about the proper number of home visits in a week, a package specifying only one home visit a week at the beginning of the intervention does not fulfill service expectations, and audit and monitoring processes are based on such expectations (see Extract 5). It is also 'normal' in the FSS to regard networks as resources in recovery processes which users are thus supposed to accept and, for instance, take part in naming the members of these networks (see Extract 6). The service package reasoning is based on the available services and the generalized idea of what the FSS users usually need. So, the service users' choices are expected to take place within certain boundaries.

Although the service users' first choices are sometimes challenged and negotiated, or are even made on behalf of them, the choice making sequences do not display the users' overt resistance or result in disagreement about the forthcoming services. In the course of the meetings both kinds of choice sequences (accepting and negotiating) alternate, so that challenging the users' first choice regarding one option does not seem to undermine the possibility of the next choice option. In all the choice sequences the professionals provide space for the users to present their wishes and choices, and in cases where they do not accept the first choices they respond by accounting and justifying their differing points of view, and eventually succeed in persuading the users about the efficacy of service options. The professionals make it clear that their preference is to accept the user choices, and when they do not, they are expected to give justifiable and face saving grounds for not accepting them.

The identification of 'choices negotiated' sequences raises a question: does this negotiation resemble shared decision making described in mental health literature? In these negotiations the service users are neither passive recipients nor active sovereign consumers, but rather the co-producers of service choices addressing their wants and needs together with the professionals (Fotaki 2009: 91-92). The professionals, for their part, aim to ensure that the users make informed choices (cf. Greve 2009: 545). The users are not responsibilized to make choices and carry the associated risks alone, but together with the professionals. Shared responsibilities and joint decisions can be argued to follow 'a logic of care' instead of 'a logic of choice' using Mol's (2008) conceptualizations: in the end service users might prefer getting interactional support and advice than having a possibility to make autonomous choices, with the associated risks (Mol 2008: 97). And if this is what they primarily want

from services, choice negotiation can be seen as compatible with the democratic user involvement.

However, from a critical perspective, choice making sequences with negotiation can be seen as examples of paternal control, leaving little room for service user involvement, either in the consumerist or in the democratic sense. The service users' preferences or own knowledge ('expertise-by-experience') are not valued, and their voices are not heard. Their first choices are accepted only if they are 'the right ones' from the point of view of a professional needs assessment or the availability of services. 'The wrong or bad choices' are challenged and are negotiated to change to more appropriate ones. To avoid such paternalism, the enabling activities of collective mental health service user movements are valuable in strengthening the capacities of service users to voice their experiences and wants in service encounters, and also in emphasizing service users' rights to have strong and even resisting voices in encounters. As Barnes and Cotterell (2012b: 2) write: 'collective action is intended to make a difference to the way in which users are treated in day-to-day interactions with services'.

Our data do not include sequences that result in disagreement or the users' refusal of the services offered. The services were also started as planned in the meeting (this information is based on our larger research data including recordings of home visits, see Section 'Data and analysis'). There are advantages to a system in which service choices are arrived at through negotiation and agreement. It is still important to ask, what would have happened if the service users, for instance, had not accepted three home visits in a week or had refused to take part in creating the supporting networks for themselves, and thus had exercised their

rights to have a say in their own lives (cf. Barnes 2009: 231)? Would this have made or make them ineligible for the FSS? This question is important, since the service users' possibilities to choose other service providers are limited. There is not a market of mental health supported housing services, and thus a range of alternative service providers for the users to choose in the municipality where the FSS is located. Furthermore, it is the representatives of the service purchasing municipality who make the final placement decisions. It is also at this point where the democratic service user involvement through collective action (Beresford 2002) and macro-level planning of services (Tait and Lester 2005) is needed to evaluate, develop and enlarge service options in mental health, and to bring forward experience based knowledge about what works and what does not work in the current range of mental health services

Note 1: Transcription symbols

FS	professional in Floating Support
AR	professional in Assessment and Rehabilitation Course
SU	service user
[	start of overlapping speech

(1)   pauses in seconds

<u>Underlining</u>   emphasis

((laugh))   an additional comment from the transcriber

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