Artikkel 2

Mathisen, V., Obstfelder, A., Lorem, G. & Måseide, P. (2016). User participation in district psychiatry. The social construction of 'users' in handovers and meetings. *Nursing Inquiry*, 23(2), 169 – 177.

User participation in district psychiatry. The social construction of 'users' in handovers and meetings

Vår Mathisen,[a] Aud Obstfelder,[a] Geir F. Lorem[a] and Per Måseide[b]

[a]*Faculty of Health Sciences, Department of Health and Care Sciences, The Arctic University of Norway, Tromsø, Norway,* [b]*Faculty of Social Sciences, University of Nordland, Bodø, Norway*

MATHISEN V, OBSTFELDER A, LOREM GF and MÅSEIDE P. *Nursing Inquiry* 2016
User participation in district psychiatry. The social construction of 'users' in handovers and meetings
An ideal in mental health care is user participation. This implies inclusion and facilitation by clinicians to enable users to participate in decisions about themselves and in the design of suitable treatment. However, much of the work of clinicians consists of handovers and other meetings where patients are not present. It is therefore interesting to study how the patient perspective is handled in such meetings and whether it forms a basis for user participation. We conducted fieldwork in three different inpatient wards in Norwegian District Psychiatric Centres. We used an interactional perspective in our analysis, where speech acts, framing and footing were key concepts. The findings show that the talk in the handovers and meetings contained five main themes and that there was a clear correlation between what was said and how it was said, and whether clinicians related to the content in a decisive, person-centred or indecisive manner. We discuss potential participation statuses for patients and their limited opportunity to influence the talk and possible decisions about themselves. Our conclusion is that handover meetings primarily function as an aid in organising clinicians' work and could ultimately be seen as counteracting user participation.

Key words: district psychiatry, handovers and meetings, mental health care, participation status, speech acts, user participation.

Hospitals are information-intensive organisations, where the staff spend considerable time handling information about patients and their treatment courses. Although electronic information systems are broadly used, face-to-face communication is still common. Professionals meet regularly in both formal and informal contexts to assess, plan and make decisions regarding the disease course and treatment of individual patients. Such meetings occur as handovers, team meetings to discuss treatment or random talk about practical tasks in the staff rooms, corridors or other meeting places (e.g. Hopkinson 2002; Sexton et al. 2004). The meetings are intended to ensure ongoing clinical problem solving, continuity between duty shifts and the distribution of practical tasks between clinicians and specialists

(Oeye et al. 2009; Fiddler, Borglin and Galloway 2010; Mayor, Bangerter and Aribot 2011). Such meetings also deal with information of an administrative and legal nature (Gunasekara et al. 2014).

The regular meetings conducted in hospitals have different purposes and involve expectations for both content and structure. Both the formal meeting structure and previous experience from attending such meetings reveal to clinicians what the meetings will deal with, and how the responsibility for providing information should be divided between them (Måseide 2008). The meetings are important for ensuring patient safety, but the participants talk *about* patients and not *with* patients (Fisher 1991; Måseide 2003; White 2004). The meetings are thus an arena that patients have no access to, although patients are the main topic of conversation.

In mental health care, handovers and other meetings are also conducted in this way. Research shows that there is also allowed time for stories about *what* patients have done

Correspondence: Vår Mathisen, Faculty of Health Sciences, Department of Health and Care Sciences, The Arctic University of Norway, MH-building, Tromsø N-9037, Norway. E-mail: <var.mathisen@uit.no>

during the day, *when, where* and *how* they did it and sometimes *with whom.* This includes the participation of the individual patient in milieu therapeutic activities (Oeye et al. 2009; Karlsen 2012).

User participation is a central tenet of guidelines for mental health care in most of the Western world, with the aim of enabling patients to play a greater role in their own health care (Rush 2004; Petersen, Hounsgaard and Vinther Nielsen 2008). The starting point for this article is clinicians' responsibility to help patients to be involved and included in decision-making processes and to participate in shaping their own treatment. Such participation may include identifying their own resources, the design of (milieu therapeutic) measures to be implemented in the ward or the planning of aftercare.

Although user participation is ideologically and humanistically 'correct', research shows that it is challenging in practice. The actual term *user participation* is abstract and devoid of context, with few explanations of how to practise it (e.g. Cowden and Singh 2007; Valenta and Berg 2010). Furthermore, we have found no explanation or examples of how user participation could be introduced into the various meetings and handovers where a great deal of patient work is conducted. We believe this can create major challenges, great responsibility and power issues for clinicians involved in such situations.

Theoretical framework

Meetings are interaction situations based on talk between individuals. They may be described as speech situations (Hymes 1997) about individuals, which involve the performative aspect of what is spoken about (Levinson 2002). Nearly, any speech act is the performance of several acts at once, distinguished by different aspects of the speaker's intention. In addition, from *what* is spoken about, and *how* the speaker *presents,* the person involved is of great significance, professionally, socially and morally. Meanwhile, the listener creates meaning and expectations *in certain ways* based on what he/she hears. This means that the speakers take up positions or 'footing' in relation to their interaction partners and the case at hand, in a more or less explicit way (Goffman 1981; Måseide 2008). These actions are performed through language use, whether spoken or written.

People have a variety of potential participation statuses. We mark ourselves as a certain type of person with specific characteristics which are often context-dependent. At the same time, we do the same with others around us; we make our interlocutor into 'something' (Goffman 1981). We may say that interaction situations are characterised by the particular participation statuses being activated, which in turn determine what kinds of interaction situations may unfold. However, as participation statuses can shift during an interaction period, the format of the situation can also change. Participants in an interaction situation can alternate between presenting themselves as professionals, moral people or people with personal and character-related identities without any relevance for professional practice. When such shifts occur, other participants are also in danger of being pulled out of the various frames. The professional activities may consequently change character and what is actually happening in the situation may become unclear.

The significance of conversation for the constitution of social positions and participation statuses plays a central role in our analysis. Conversations are speech activities that guide the interaction format and create opportunities for understanding and further action for those who participate, but also for those who constitute the subject matter, such as patients.

Purpose of the article

As much work with patients takes place in the absence of patients, we find it interesting to examine the participant statuses attributed to patients in handovers and other meetings. The research questions for the article arise from expectations of user participation based on health policies and patient rights and from the theoretical argument above. Our questions are as follows: What is discussed in the handovers, which participation statuses are attributed to patients through the talk and what consequences may this have for user participation?

METHODS

Methodological approach

This study forms part of a larger study to examine the practice of user participation in psychiatric wards. In this study, our method involved participant observations and interviews, following the principles described by Hammersley and Atkinson (2012). We conducted three intensive periods of fieldwork in three inpatient wards in three different District Psychiatric Centres (DPCs) in Norway. This took place over a period from autumn 2011 to spring 2012. The authors have extensive experience from professional health work as clinicians and researchers. The first author collected the data. She has professional background and clinical experience from the same type of work as in this study, but in other institutional settings and phases of treatment.

Presentation of the context of the fieldwork

The DPCs had 7-15 beds, and were all organised as inpatient wards where patients were mainly admitted voluntarily. Many patients were admitted as acute cases, and the stays were intended to be short, ranging from three days to about eighteen weeks. The clinicians described the patients as very ill on admission, and most patients were hospitalised because of high suicide risk.

The centres offered treatment services to people with general mental disorders. The health care involves diagnosis, treatment and testing of medications. The wards were run on milieu therapeutic principles, as arenas to practise social skills with support from staff and fellow patients.

The professional composition of the three wards varied somewhat, and nurses predominated in all of them. Two had a broad interdisciplinary composition of doctor/psychiatrist, nurses, psychiatric nurses, occupational therapists, physiotherapists, social workers, child care workers, social educators and psychologists. One ward's staff was mainly composed of nurses and nursing assistants.

The staff had overlapping reports between shifts and shared information of relevance for the professional work. The clinicians were constantly rotating and the first author did not meet the same staff at each meeting. No patients were present at the handover meetings which lasted about one hour and took place in staff rooms. In addition to the daily handovers, all three wards had one or more team meetings each week (about three hours) to discuss patients' treatment in greater depth. One ward practised separate treatment meetings with each patient, if the patient wanted and could cope with this. The first author did not attend these.

Data collection

The fieldwork lasted just over a week at each location, giving a total of 200 hours of observation. Twelve individual interviews and one focus group interview with various clinicians were conducted. The study includes 69 clinicians and 25 patients.

The first author accompanied the staff in their work and participated in most of the ward routines such as the handovers and treatment team meetings which are the focus of this article. These meetings were a key feature of the medical and mental health work. Field notes were taken from the observations, with an attempt to reproduce them as precisely and in as much detail as possible.

All interviews were recorded on a dictaphone and printed out. The individual interviews ranged from 20 to 120 minutes. The main topic was the informant's thoughts about user participation. The focus group interview was conducted after the fieldwork, when the analytical process was well underway. Together with eight people (five nurses and three allied health staff), data were then discussed, elaborated, supplemented and validated.

Ethics

The study was approved by the Norwegian Social Science Data Services (NSD). All staff consented to participate. A separate information sheet and consent form were given to patients who consented to the first author attending handovers and treatment team meetings. To maintain anonymity in the presentation of results, we do not distinguish between professionals, except in a sequence where the focus is on interdisciplinarity.

Data analysis

One starting point for our analysis was the empirical data. We provided an overview of the material and identified regular patterns and features relevant for the research questions. In this process, we were inspired by King (2004). To ensure rigour in the interpretation phase, throughout the analytic process, the first author had the responsibility for presenting new interpretations in regular supervision/discussion meetings with the other authors. She also regularly checked out the raw data during the entire interpretations process.

For this article, the research questions and the theoretical framework led our attention towards interaction situations and the talk involved in handovers and other meetings. Further, findings was organised in two themes: 'speech activities' and 'ways of approaching the topic'. Speech activities refer to what the professionals talked about and discussed in the handovers and meetings. We analysed the talk to contain four main themes (forms of speech activity) of relevant to this article. Firstly, they talked about the patients as *case constructions*. This talk involved the patients name, age, diagnosis and medication. Secondly, they talked about *the life of the patient outside the institution*. Thirdly, they talked about *milieu therapeutic activities*. Fourthly, the staff talked about *organisation of the clinicians' work*, before they ended the meetings by talking about themselves.

Our analysis also showed further that *what* the professionals talked about had implications for how they interacted and approached the topic of conversation in terms of interaction. This they did in three fundamentally different ways, or approaches, namely *a standardised approach*, *a patient-centred approach*, and one approach which led to *indecision*. In presenting these findings, we start with the four types of speech activities, then the three principal approaches to talk-

ing at the handovers and meetings, in this particular order. This will be seen in light of the different participation statuses that are attributed to patients through talk, and possible consequences this may have for user participation.

Findings

SPEECH ACTIVITIES

In all the wards, the reports had a predictable structure in terms of participants, organisation and themes. The themes (speech activities) were presented in the same order in all wards, with an inexplicit transition between them. Reports at the handover from day to evening shift followed the same structure, but evening handover reports were often briefer.

CASE CONSTRUCTIONS

The meetings started by presenting all inpatients alphabetically, followed by their room number, time since admission and planned discharge date. If the patient was known to the staff, only a brief status report was provided:

> Patient X got up at 7.10 and has had breakfast. He has been given medicines and is now in his room. He looked fine (field notes, Ward A, 2011).

Patients' medication was also discussed, especially connections between behavioural changes and dosages. Then patients who had been on leave were discussed; here a key point was whether patients with addictions had 'cracked' on leave and if so what drugs they had taken.

When the most recently admitted patients were presented, the admission diagnosis was usually mentioned. A recurring theme was also the manifestation of the symptoms of the diagnosis and how this had changed during hospitalisation. Here, related issues were brought up, such as possible causes of the admission and diagnosis, any extra care and treatment needed or the possibility of self-harm or attempted suicide. Other topics were patients' challenges related to personal hygiene, sleeping problems, appetite and nutrition, ability to cope with everyday life and work and patients' concerns for their children.

THE LIFE OF THE PATIENT OUTSIDE THE INSTITUTION

Other patient issues were of a practical nature. Many patients needed help with their mobile phones and topping up, redirection of post, money matters and unpaid bills. For some patients, housing was a recurring theme. Some had not paid the rent and were in danger of being evicted while others were actually homeless. In one of the fieldwork

periods, the weather was extremely cold and several patients needed help to check the water and pipes in their homes. Pets could be an equally important point of discussion for some patients:

> A patient's cat is staying with a relative who lives far away, and the patient has no car to fetch it. Several people mention that the patient has said that the cat is his main reason to keep going as it gives him company, so he has to 'get his act together' to look after it properly. They conclude the discussion by deciding to try to get the weekend staff to bring the cat (field notes, Ward B, 2011).

MILIEU THERAPEUTIC ACTIVITIES

In the mention of patients' participation in milieu therapeutic activities, the presentation of each patient followed the everyday rhythm of the wards: when they got up and went to bed, how far and in what way they had participated in communal meals and activities such as morning meetings, fitness groups, sports and hobby activities or trips to the shop or other outings. This was mostly mentioned at the handover between day and evening shift. Here, a typical sequence is described:

> A clinician tells the others at the handover about the day's outing. This leads to a dialogue between the clinicians about how pleased they were that some patients had taken the initiative to join various activities on the outing, and the talk ends with a brief discussion about how signs of involvement and interest in the outside world represent improvement (field notes, Ward B, 2011).

However, a brief mention of how individual patients had participated in ward activities was more typical. On the other hand, the clinicians often just said one sentence that there was nothing special about the patient.

ORGANISATION OF THE CLINICIANS' WORK

Towards the end of the meeting, the most common tasks were distributed: who would be the daytime contact person for individual patients and who would be responsible for the medication of patients. There was also discussion of who would be responsible for communal tasks with patients, particularly meals, morning meetings and activities. It was decided who would attend other meetings and when staff would have breaks. Other practical tasks were allotted, such as cleaning the rooms of patients being discharged and preparing these for new patients:

> A clinician states that a patient will be discharged during the morning to go home. She says that they must remember to unlock the patient's medicines. She wants the room to be arranged and inspected. The milieu staff says that they will do this (field notes, Ward A, 2011).

Ways of approaching the topic

There was strikingly little discussion of what the patients themselves may have wanted or their views on what was decided. An analysis of what clinicians talked about at handovers clearly shows a connection between *what* was discussed and *how* it was discussed, and how clinicians related to it.

A STANDARDISED APPROACH

The staff consistently talked about patients' health and turned their state of health *into* tasks that the wards had routines to handle. This also applied to everyday practical tasks with patients, stays in the wards and rooms to be prepared. The person leading the handover meeting could generally view the patient record on a computer, and one ward had a big screen. In any case, the person read aloud to the others, as here:

> A patient says she can see shadows on the walls of her room, and she says someone has put something in her water: it tastes of blood. Another clinician interrupts, saying he has talked a lot with the woman, and she wants to be involved in understanding her own illness. Another clinician asks the others if they think the patient drinks enough fluids. This leads to a discussion about the patient's fluid balance, as it must be nasty and frightening to drink something she feels tastes of blood. The proposed solution to the challenge of fluid balance is yellow juice instead of red. Yellow juice is perhaps less reminiscent of blood than red juice (field notes, Ward A, 2011).

During this sequence, there was never any question of whether the yellow juice should be discussed with the patient, nor any talk of assisting the woman in her initiative to understand her illness better or connect her to a professional who could help.

On other occasions, patient information was presented more as statements of facts. For example, at one handover, it was said that one of the female patients had received a sedative. She had said that her husband was violent and dreaded a visit from him and their children. The clinicians' suggestion for resolving the situation was practical in that they would find another meeting place for the family than the communal living room on the ward. This was to spare other patients from possible unpleasant situations.

A PATIENT-CENTRED APPROACH

It happened that the information provided led to discussions on how the patients themselves could be involved in tasks, with a focus on patient wishes. Patient views were particularly emphasised when the staff were affected emotionally:

> A young patient has been informed of an unexpected death in his family. One clinician says that the patient has said he wants to meet his family and arrangements have been made for his flight, with an agreement that his family would collect him at the airport. The talk reveals that the DPC has lent the patient money for the ticket (field notes, Ward A, 2011).

In other cases, it was the patient's illness and suffering that affected staff. One patient experienced constantly having his dead relatives around him, in the garden and in the bedroom. The patient's story was mentioned in several handovers, but without any additional measures being implemented. In one handover, however, one clinician considered the situation as serious:

> A clinician voices her belief that the man's experiences are a great strain for him, and that the patient has confirmed this to her. She says several times that she is worried about the man and that she does not think this patient should be so much alone with his dead relatives in solitude (field notes, Ward A, 2011).

Those who heard the report said they agreed with this, and it was decided that weekend staff should work out a plan with the patient to improve his care when he got his hallucinations. Proposals to adjust treatment and involve patients in this were justified on both human and professional grounds:

> A mother and her young adult daughter who will be admitted together, leads to reactions among the staff. A clinician says she considers it necessary that the teams prepare their stay thoroughly and include the mother and daughter in the planning. The clinician raises several issues such as how to conduct group therapy and manage confidentiality (field notes, Ward A, 2011).

In situations where clinicians became engaged in this way, talk about the patients took on a distinctive form, typically involving both how patients were talked about and the participants' insistence on a response. An example of this is a discussion of how a patient's wish *not* to take medication was taken seriously. At the meeting, the patient's record was on a big screen so that everyone could read the patient's wishes simultaneously:

> The leader of the meeting reads aloud: 'Maren does not want to take her medicine. She says that she feels like a failure if she takes medication'.
>
> Doctor: Ok. Then we'll look into it. How many millilitres is she getting?
>
> Nurse 1: 10 millilitres.
>
> Doctor: How does she seem otherwise?

Occupational therapist: She says she feels completely worn out at the moment, and has major concerns. She has big care tasks to cope with, in addition to herself.

Doctor: Hmm… could a home care worker for a period be an idea?

Social worker: I'll check, but then I think there should be a report by a psychologist. That would help the application.

Psychologist: I agree. I'll talk to Maren about this. I have frequent meetings with her, so it would be natural to mention it.

Doctor: But otherwise she may need help to organise and make priorities in her life. She has so many burdens…

Physiotherapist: I've touched upon stress management with her, but I can have a proper talk with her about this.

Doctor: Yes, do that please…

Nurse 2: But it's a dilemma that she doesn't want to involve her family. She says she wants to cope with everything herself. We must follow this up. They know nothing at work and she's afraid of losing her job.

Doctor: I agree. Who will follow this up? I'll talk to Maren about the medicine (field notes, Ward B, 2012).

This dialogue is a good example of how the professionals handled the fact that a patient did not want her medicine, in an interdisciplinary way. Having positioned themselves in professionally specific ways, the clinicians agreed on who should take part in a talk with the patient for further planning and cooperation.

INDECISION

The talk at handovers about certain patients was sometimes performed with inaction and indecision. This was typically expressed by statements such as: '*Otherwise, nothing special*', which was commonly heard on all the wards. This statement was sometimes in a questioning tone, followed by a few moments' silence. There were usually no comments. That meant that under the circumstances, everything was going as expected with respect to disease progression and medication and the general work on the ward.

Indecision as an approach also involved the lack of decisions. In situations characterised by indecisiveness, the atmosphere was more informal and unfocused. Patient information was not only read from the computer but also supplemented by the others in the room when they seemed to find something relevant to say. Discussions arose, but not visible and audible decisions:

The staff talks about a man who has just been admitted. He is in a moderate depressive state. He has been in an incident

that has since marked him. Those present respond with compassion, and continue to drink coffee. After some silence, they begin to talk about the incident involving the patient and how awful it is that he is having such difficulties. After a while they go on to talk about the next patient (field notes, Ward C, 2012).

Another phrase that recurred in the wards was the description of some patients as '*hotel guests*'. This indicated that the patients did not get sufficiently involved in their treatment or were against it. This form of expression was heard in all wards, but some used the phrase more than others:

The handover included a discussion that arose from apparent irritation about one of the patients. This patient had neither behaved nor performed activities as expected. One clinician exclaimed that the patient pretty much behaved like a hotel guest. The others confirmed this by nodding their heads. One added that people needed to work in the wards, they're not in a hotel! (field notes, Ward C, 2012).

DISCUSSION

The content of the talk about patients at handover meetings was relatively predictable in structure. The clinicians present spoke and positioned themselves in relation to this content in three fundamentally different ways:

Firstly, the staff often related to the patients by making decisions on their behalf. This applied to both clinical assessments and practical personal factors. In this way, patients appeared as passive recipients of expert help and were placed in a traditional patient role. *Secondly*, the staff sometimes related to the patient in a person-centred way. When they were emotionally affected by patients, they altered the routines. The particular condition and disease manifestation of those patients was given more space and more abilities of the patient were addressed than usual. Patients were personified and given a more prominent role in knowledge about their own illness and what was needed to recover and cope with life with a mental disorder. *Thirdly*, staff related to patients in a hesitant manner. An atmosphere was created that something had to happen, but none of the staff took the initiative to activate the patients. In such situations, the staff emerged as indecisive and patients were turned into recipients of services, like customers, who themselves were responsible to make an effort to participate in activities and treatment. The term 'hotel guest' was used in several cases.

The potential participation statuses that were activated during the handovers and discussed here are *passive, active* and *unclear* participation status.

Passive participation status

Central to the exchange of information and discussions at handovers and other meetings were the active attempts by clinicians to correct the pathology and/or alleviate the symptoms of patients. Clinicians' understanding of the relationship between the disorder and the patient's needs was expressed in decisions about certain actions to be performed. These actions, such as the clinicians' work, were grounded in medical information and not in patients' experiences of their illness and situation. Patient needs were thus only *indirectly* involved. This is also discussed in other research (e.g. Hardey, Payne and Coleman 2000; Tait and Lester 2005; Fiddler et al. 2010).

In themes and issues that indirectly referred to the patient's life outside the institution, the patient's voice or views were also often omitted in the handover reports. Discussions of practical matters did not include, for example, whether the patient should buy the phone top-up, or whether the room could be cleaned another day. When such matters were talked about, the life world (see Mishler 1984) of the patient was turned into something practical to be dealt with, as with the woman with the violent husband or the woman who got yellow juice. Such passivisation of these women helps to maintain the impression that psychiatry still traditionally acts on behalf of patients precisely because they are mentally ill. This can mean that the organisation and administration of patients' mental disorders displace the human aspects of treatment (Tait and Lester 2005; Borg et al. 2009).

Active participation status

When people position themselves morally it is because they feel that there are good reasons for why the other person behaves as he/she does, and allow themselves to be affected. (White and Stancombe 2003). Goffman (1981) also highlighted precisely the consequences, or 'benefits' of involvement. He stressed that participation statuses are related to actions and activities and thus become a product of the practice, as repositioning simultaneously takes place in the frame shift. So when clinicians get involved, a different participation status is mobilised for the patient.

In the situation with the patient who experienced a sudden and unexpected death in his immediate family, there was a common positioning. He was *moved out* of his patient status and more clearly became a fellow human being, a young family man who had lost someone abruptly and unexpectedly, which is something we all fear. Other factors more important than the medical ones were introduced into the

talk. Events in the patient's life affected the clinicians' involvement and the discussion. Procedures related to medication and participation in therapeutic activities were overlooked. Based on situational action, the talk revolved around practical measures to enable the patient to attend the funeral.

We have also shown that patients are assigned an active participation status in the meetings in different ways. One way is when clinicians become personally involved on the patients' behalf and act as ambassadors for their cause. This creates a person-dependent practice that is in danger of becoming too personal and random and no longer part of routine.

Another way of viewing the ascription of active participation status to patients is to emphasise the organisational significance. The study shows that when patients' explicit 'orders' or statements were entered into the patient record, they increasingly set the agenda for the meeting and the talk. The use of technology such as a projector and big screen also gave the clinicians present a more equal position. Furthermore, they had the opportunity for what Goffman (1967) calls focused interaction, which was also patient-directed.

A third way to view the allocation of active participation status is to emphasise interdisciplinarity supported by the patients' 'orders'. In this way, many different professional perspectives were adopted. Here, the staff could provide additional knowledge and experience where patients' knowledge and understanding may have been insufficient. Various positions and statuses were ascribed by and to both staff and patients. This opened up different relationships and themes in the interaction, but also a distribution of responsibilities. This was dependent on clinicians 'joining in' issues they considered relevant.

In this way, the medical and mental health work became inclusive and dialogic, including all those present, *for* the patient, as in the case of the woman who said she did not want her medicine. In a few minutes, the clinicians had established a thematic overview or frame for her medication, coping experiences, stress management and caring. The way this was expressed may be understood as founded in both personal consideration and professional and institutional culture. The main impression was of an attempt to understand the woman as more than 'just' a patient. With her written request, she participated (indirectly) in the talk about her health situation and was taken seriously in her ambivalence towards her medicine. She was also a mother and a working woman whom the staff aimed to restore to her different roles; similarly, staff took seriously the man who needed help to fetch his cat for maintaining his participation

status as care giver. This can also be understood as accountability of patients.

This shows that speech and linguistic expression are inextricably linked to the contexts in which they occur and help to create. Speech and linguistic meaning emanate from specific activities and situations; at the same time, the words make the activities and situations possible. This understanding of speech emphasises the *performative* functions of language (Austin 1976).

Unclear participation status

A recurring phrase was '*patients must not be hotel guests*'. This suggests that there might have been a perception of how patients *ought to be*, as opposed to neither behaving nor participating in activities as the staff expected. But the staff seemed to leave it to the patients to find out how to stop being a hotel guest. At the same time, it is interesting that the *hotel guests* were the most visible patients, as they held their own opinions. But the requirement to cease to be a hotel guest is not a real choice, when clinicians by virtue of their professional status demand patients to do so. When a person does not have a rational choice, but is pressured or forced to do something, it is coercion (Wertheimer 1993). Expertise is power and is necessary in professional practice (Måseide 2008). But the danger of paternalism, or excessive faith in one's own professional excellence, is the risk it involves of not accommodating the other's intentions and desires (Wertheimer 1993). This brings us to the very core of user participation.

This study shows that the talk in the handovers and other meetings makes patients into products of medical and interdisciplinary knowledge, procedures, technology, milieu therapy, laws, norms, rules and more. One might say that the *patient* is a social construction, but unclear as a *user*. Paradoxically, mental health care aims to help the patient to recover and become clearer in terms of needs, independence and free will. To create and encourage such patients, the professionals around them should 'cheer on' patients with clear opinions and wishes. But this kind of patient tends to be referred to as a hotel guest, or someone who 'doesn't want to be a user'. Is this not a complete misunderstanding?

CONCLUSION

Mental health care is a service organisation where handovers and meetings are the arena of the staff. Here, work with very ill patients with serious disorders is discussed and organised within a framework of certain resources, professional ideologies and other clinical structures. We have shown that the

talk is expressed through various types of speech activities, such as case construction, life of the patient outside the institution, environmental therapeutic activities and the organisation of the clinicians' work. There is also a connection between what is said, how it is said and how clinicians relate to it.

The handovers and meetings can be understood as types of activities that express various realities. In these realities, clinicians speak on behalf of and about patients, although the goal of user participation is to involve the patients' voice. The realities produced by the handovers construct the patients as social categories. Patients are present as representations and not as real people. The representations of patients are constructed at certain times, with certain clinicians present. The talk at the handovers ascribes a patient with qualities and identities and makes him/her into a kind of participant in a particular type of situation. We see that patients are generally given a passive participation status in relation to what concerns them and that the clinicians' main focus is to create and delegate tasks to address the function of the psychiatric ward.

The institutional framework governs the handovers and meetings. This suggests that the wards are based on traditional work structures and reproduce patients suitable for a psychiatric practice. This challenges the patients' opportunity for user participation and their right to be involved in medical decisions and design of their treatment. The study also shows that handovers *can* create interaction situations that enable patients to be something else than 'just' patients in the traditional sense. To achieve active participation status and thus increased possibility of participation, patients are dependent on the staff showing personal commitment or advancing their cause as ambassadors. The study shows that handovers and other meetings can be seen as *basic conditions of existence*, as they distribute participation statuses through the construction of users. If this is not problematised, we are afraid that patients' right to user participate can be dependent on a random and/or private involvement from professionals. That is simply not good enough for neither the patients, professionals nor the welfare state.

REFERENCES

Austin JJ. 1976. *How to do things with words.* Oxford: Oxford University Press.

Borg M, B Karlsson, J Tondora and L Davidson. 2009. Implementing person-centred care in psychiatric rehabilitation: What foes this involve? *Israel Journal of Psychiatry and Related Sciences* 46 (2): 84–93.

Cowden S and G Singh. 2007. The "user": Friend, foe or fetish?: A critical exploration of user involvement in health and social care. *Critical Social Policy* 27: 5–23.

Fiddler M, G Borglin and A Galloway. 2010. Once-a-week psychiatric round or daily inpatient team meeting? A Multidisciplinary mental health team's experience of new days of working. *International Journal of Mental Health Nursing* 19: 119–27.

Fisher SA. 1991. Discourse of the social: Medical talk/power talk/oppositional talk? *Discourse and Society* 2: 157–82.

Goffman E. 1967. *Interaction ritual: Essays in face-to-face behavior*. New Brunswick, NJ: Aldine.

Goffman E. 1981. *Forms of talk*. Philadelphia: University of Pennsylvania Press.

Gunasekara I, T Pentland, T Rodgers and S Patterson. 2014. What makes an excellent mental health nurse? A pragmatic inquiry initiated and conducted by people with lived experience of service use. *International Journal of Mental Health Nursing* 23: 101–9.

Hammersley M and P Atkinson. 2012. *Feltmetodik: Grunnlaget for feltarbeid og feltforskning [Field methodology: The foundation of fieldwork and field research]*, 7th edn. Oslo: Gyldendal Akademisk.

Hardey M, S Payne and P Coleman. 2000. 'Scraps': Hidden nursing information and its influence of the deliveries of care. *Journal of Advanced Nursing* 32: 202–14.

Hopkinson JB. 2002. The hidden benefit: The supportive function of the nursing handover for qualified nurses caring for dying people in hospital. *Journal of Clinical Nursing* 11: 168–75.

Hymes D. 1997. Language in society. In *The early days of sociolinguistics: Memories and reflections*, eds CB Paulston and GR Tucker, 243–5. Dallas: SIL International.

Karlsen K. 2012. Idaler og realiteter i moderne psykisk helsearbeid [Ideals and realities of modern mental health care]. *Nordisk Tidsskrift for Helseforskning [Nordic Journal of Health Research]* 2(8): 3–15.

King N. 2004. Using templates in the thematic analysis of text. In *Essential guide to qualitative methods in organizational research*, eds C Gassel and G Symon, 256–69. London: Sage.

Levinson SC. 2002. Activity types and language. In *Qualitative research methods*, ed. D Weinberg, 193–220. Oxford: Blackwell.

Måseide P. 2003. Medical talk and moral order: Social interaction and collaborative medical work. *TEXT* 23 (3): 369–403.

Måseide P. 2008. Profesjonar i eit interaksjonistisk perspektiv [Professions in an interactional theoretical perpective]. In *Profesjonsstudier [Profession studies]*, eds A Molander and LI Terum, 367–85. Oslo: Universitetsforlaget.

Mayor E, A Bangerter and M Aribot. 2011. Task uncertainty and communication during nursing shift handovers. *Journal of Advanced Nursing* 68 (9): 1956–66.

Mishler EG. 1984. *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ: Ablex.

Oeye C, AK Bjelland, A Skorpen and N Anderssen. 2009. Raising adults as children? A report on milieu therapy in a psychiatric ward in Norway. *Issues in Mental Health Nursing* 30: 151–8.

Petersen K, L Hounsgaard and C Vinther Nielsen. 2008. User participation and involvement in mental health rehabilitation: A literature review. *International Journal of Therapy and Rehabilitation* 15: 306–14.

Rush B. 2004. Mental health service user involvement in England: Lessons from history. *Journal of Psychiatric and Mental Health Nursing* 11: 313–8.

Sexton A, G Chan, M Elliot, J Stuart, J Jayasuriya and P Crookes. 2004. Nursing handovers: Do we really need them? *Journal of Nursing Management* 12: 37–42.

Tait L and H Lester. 2005. Encouraging user involvement in mental health services. *Advances in Psychiatric Treatment* 11: 168–75.

Valenta M and B Berg. 2010. User involvement and empowerment among asylum seekers in Norwegian reception centres. *European Journal of Social Work* 13 (4): 483–501.

Wertheimer A. 1993. A philosophical examination of coercion for mental health issues. *Behavioral Sciences and the Law* 11: 239–58.

White S. 2004. Accomplishing "the case" in pediatrics and child health: Medicine and morality in inter-professional talk. *Sociology of Health and Illness* 24 (4): 409–35.

White S and J Stancombe. 2003. *Clinical judgement in the health and welfare professions: Extending the evidence base*. Maidenhead, UK & Philadelphia, PA: Open University Press.