

## Exploring ‘person-centredness’: user perspectives on a model of social psychiatry

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### Abstract

This paper explores service users’ experiences of a ‘person-centred’ mental health service. We describe the development of a model of social psychiatry that places the emphasis on the experiences of the person within social and political contexts. This establishes the foundations of a ‘person-centred’ approach, the values of which are described briefly. The results of interviews with 20 people are presented, in which their experiences of the service are explored in detail. These interviews reveal the struggle that lies at the heart of the professional–service user dialectic, which relates to issues of institutional power, roles and responsibility, and which places professional staff in conflict with the very notion of ‘person-centredness’. No matter how ‘person-centred’ a mental health service may strive to be, there remain serious obstacles to the full realization of this approach. Despite this critique, there were many things that were valued by those who used the service. More detailed qualitative studies are required to explicate the complex relationships and paradoxes that emerged.

**Keywords:** person-centred medicine, qualitative methodology, rural mental health, social psychiatry

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### Introduction

The government has recently declared that the policy of community care for those suffering from mental health problems has failed (Department of Health 1998, press release). This, together with the widespread dissatisfaction expressed by service users about mental health services (Campbell 1989, Pembroke 1993, Rogers *et al.* 1993) suggests that psychiatry has failed to develop models of mental health and illness that are appropriate for community settings (Thomas *et al.* 1996). Jones (1988) has pointed out that as the care of patients shifted into an increasingly hostile community, psychiatry rejected social models, adhering instead to a strict medical model, so that it became distanced from the day to day experiences of psychiatric patients. The origins of psychiatry

in Victorian asylums favoured the development of a medical model that overlooked the importance of social factors in mental health problems. The purpose of this paper is to describe users’ perspectives on a model of social psychiatry that has much in common with the earlier work of Querido (1966), and more recently, Romme (1993), both in Holland. Romme’s social homeostasis model understands mental health problems in terms of attempts by the person to adapt to adverse social environments. This means that attempts to help the person should focus on rectifying social adversity, rather than medically treating a psychiatric disorder.

### The service

The study examines an eight-place community support unit (CSU) serving a sector population of 31 500 people in rural Wales. The Community Trust provides mental

\* Since this paper was written one of its authors, Sharon LeFevre, has tragically died. The remaining authors would like to dedicate this paper to her memory.

**Box 1** Characteristics of the Patient-Centered Clinical Method (Stewart *et al.* 1995)

<p>Exploring both the disease and the illness experience</p> <ul style="list-style-type: none"> <li>● Differential diagnosis</li> <li>● Dimensions of illness (ideas, feelings, expectations, and effects on function)</li> </ul> <p>Finding common ground regarding management</p> <ul style="list-style-type: none"> <li>● Problems and priorities</li> <li>● Goals of treatment</li> <li>● Roles of doctor and patient in management</li> </ul> <p>Enhancing the doctor–patient relationship</p> <ul style="list-style-type: none"> <li>● Characteristics of the therapeutic relationship</li> <li>● Sharing power</li> <li>● Caring and healing relationship</li> <li>● Self-awareness</li> <li>● Transference and countertransference</li> </ul>	<p>Understanding the whole person</p> <ul style="list-style-type: none"> <li>● The ‘person’ (life history and personal and development issues)</li> <li>● The context (the family and anyone else involved in or affected by the patient’s illness: the physical environment)</li> </ul> <p>Incorporating prevention and health promotion</p> <ul style="list-style-type: none"> <li>● Health enhancement</li> <li>● Risk reduction</li> <li>● Early detection of disease</li> <li>● Ameliorating effects of disease</li> </ul> <p>Being realistic</p> <ul style="list-style-type: none"> <li>● Time</li> <li>● Resources</li> <li>● Team building</li> </ul>
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health services for a bilingual population of 243 927 (1991 census), covering five sectors, each served by community mental health teams (CMHTs) and a District General Hospital (DGH) of 54 beds. Until 1991 the main service provision for the sector was a distant Victorian asylum. The CSU was converted from a private dwelling and opened in July 1993. Four months later it was fully operational, providing a local alternative to DGH admission for people with acute mental health problems. In its first year of operation it successfully reduced admission rates to the DGH unit (over 40 miles away) by 50% (Thomas *et al.* 1995). The unit is staffed by a nurse manager, deputy nurse manager, five staff nurses and six health care assistants, and offers 24-hour cover. Medical input is from a consultant psychiatrist, registrar and clinical assistant in psychiatry. Emergency cover is provided by local GPs. Here the development of the model, and how service users regarded it is described.

### Developing the model

The model emerged from a series of staff meetings before the unit opened. Three principles emerged: valuing the client as a person, concentrating on the social origins of mental health problems, and belief in the normality of mental health problems.

#### *Valuing the client as a person and an individual*

Staff produced a set of value statements that characterized the service they wished to provide. A central feature of this was the belief that clients should be valued as individuals. The philosophy may thus be described as ‘person-centred’ as it corresponds with recent definitions of the concept (Welsh Office 1989, Williams & Grant

1998). It has much in common with the ‘patient-centred’ clinical method outlined by Stewart *et al.* (Box 1).

To operationalize this philosophy it was necessary to produce a more detailed statement. Two themes proved valuable here:

- Clients’ problems (rather than professional re-narration of the problem) should be at the centre of service provision;
- The value of a humanistic approach through attempts to empathize with patients.

Consequently, the service should recognize the patient’s perspective and the uniqueness of each person’s problems. This was further operationalized from a set of value statements developed at staff meetings (Box 2).

#### *Concentration on the social origins and consequences of mental health problems*

There are two main problems with the medical model. It disregards the meaning of a mental health problem and labels the person’s experiences as abnormal (Thomas *et al.* 1996). Staff discussions expressed the belief that adopting a person-centred approach meant dealing with the social origins and consequences of mental health problems, and subordinating the traditional emphasis on diagnosis and treatment. Biological changes may correlate with symptoms but these are regarded as *post facto* phenomena (Thomas 1997). If a person is to be helped to live independently in the community, a range of personal and social problems must be addressed. This means that the emphasis is placed on the person’s social relationships and situation, such as work (or lack of it), poor housing, benefit problems, loneliness, and lack of time structure.

**Box 2** Dryll y Car value statements

- I want individual care geared to my needs and the needs of significant others.
- Courteous friendly environment.
- Being informed of what is going to happen throughout.
- Understanding what is expected.
- Concerned, friendly competent approach when admitted.
- Help retain independence.
- Consideration of self-esteem.
- Respect for individual.
- Patient participation in their own programme of care.
- Sensitive to need.
- We want to give people a good experience.
- It should be realistic.
- I want to learn and grow.
- I want a place that is safe and secure, not intimidating.
- Patients/residents are part of our team.
- Patients/residents are partners in care.
- Patients/residents are equal to us.
- We should not label people.
- I want to feel that people care.
- I want to feel that staff are friendly to me.
- I want to feel that I belong.
- I want to feel secure enough to leave.
- I want a plan to stay well.
- We are part of a community and not apart from it.

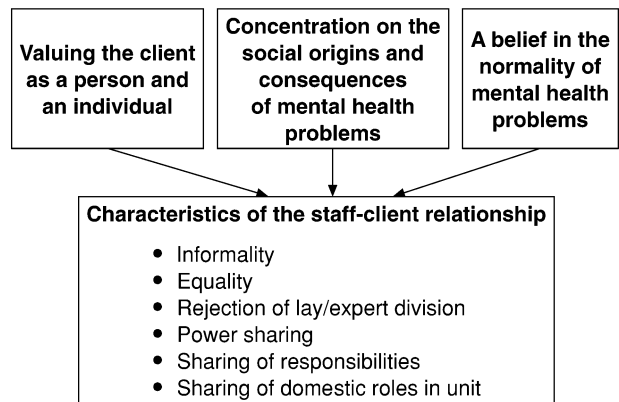
*The normality of 'mental health problems'*

The social model implies that mental health problems exist on a continuum with other people's experiences and problems. For example, a person who hears voices when distressed is no different in terms of 'normality–abnormality' from a member of staff who is extremely upset after a divorce. This has two consequences for staff–patient relationships. First, it avoids the inequality which may arise when a 'normal' person cares for an 'abnormal' one. Second, the patient becomes the expert because she both defines the problem and, ultimately, holds the solution. Biological perspectives are not entirely ignored, and many patients receive medication, although the limitations of this are acknowledged.

An important implication of this model is that the consultant psychiatrist has a much less prominent role in the patient's care. Consultant-led services tend to medicalize social problems. Here, nursing staff develop and implement care plans directly with patients, and without psychiatric input. The most important aspect of the consultant's role is that of supporting nursing staff in their work, and occasionally being consulted over more difficult problems (Figure 1).

**Study aims**

In practice, these three elements influence the nature of the relationship between the patient and staff, but



**Figure 1** The impact of unit philosophy on the staff–client relationship.

the successful implementation of a 'person-centred' philosophy depends on the extent to which staff–client relationships conform to the elements in Figure 1. The critical issue here concerns clients' perceptions of staff relationships, so a study was commissioned to explore clients' views of the service, and especially their views of the relationships between clients and staff.

**Method**

The theoretical stance adopted here regards people as social actors who interpret and strive to make sense of their experiences. Individuals construct the social world in which they live and through this interpret and make sense of it; such constructions are seen as self-sustaining and self-renewing. This study explores and describes these constructions. Such an aim requires a qualitative approach (Mays & Pope 1996). We used a grounded theory approach (Glaser & Strauss 1968, Strauss & Corbin 1990) and tape-recorded, in-depth interviews with clients. Our intention is not to produce results that are widely applicable, but to identify the issues and problems which exist locally in relation to the research question. A further quantitative study would be required to establish the relevance of these findings for similar units elsewhere.

**Sample**

We adopted a 'purposeful' sampling strategy (Kuzel 1992), to cover clients' experiences of as many different aspects of the service as possible. The CSU has five service functions (Table 1). Twenty individuals were selected from the unit's database in alphabetical order until each service function was represented by at least four potential interviewees. Most people had used the CSU for more than one function. Five men (25%) and

**Table 1** Service functions of Dryll y Car

Service function	No. of clients interviewed with experience of service function
Step between DGH acute unit and home	8
72 hour acute bed for short-term problems	Unable to identify
Regular, planned admissions for the resolution of problems	10
Regular, planned admission for respite care	4
24 hour support network in the community	13

Total number of interviews = 20.

15 women (75%) were interviewed. This compares with the 1995 admission ratio of 65% women and 35% men (Table 1).

### Interviews

Clients were contacted by letter and invited to participate. Interviews were not performed by CSU staff, and took place in clients' homes, to set interviewees at their ease and increase their sense of control over the conversation. There was concern that interviews carried out in a clinical setting might result in interviewees framing their responses in terms of medical discourse. The researchers tried hard to prevent the interview becoming a medical consultation, and thus creating a situation in which a lay discourse could develop. Interviews were relatively unstructured and lasted for approximately one hour. The interviewers were employed jointly by Social Services, the voluntary sector, user group and the Community Trust.

### Analysis

Seventeen interviews were tape-recorded and transcribed. On three occasions equipment failure meant that extensive notes taken during and immediately after the interviews had to be relied upon. All transcripts were checked for accuracy. Data were examined for themes relevant to the research question, and three categories emerged: casualness, independence, and sense of equality. These were explored in greater detail to identify clients' positive and negative views and experiences. From this, a fourth category emerged: 'role confusion'. Pseudonyms have been used in all the quotations.

### Results

The interpersonal aspects of the service were the source of greatest satisfaction and dissatisfaction. This accords with research elsewhere, which indicates that interpersonal aspects of care are the main determinants of satisfaction (Vuori 1991). Relationships here were viewed in terms of casualness, independence and sense

of equality. While the nature of the staff relationships was perceived as different from that experienced elsewhere, significant new problems emerged, relating to conflicts between roles and philosophy.

#### *Casualness*

Several clients described CSU staff as having a more 'casual' attitude than staff in the other units. Relationships were regarded as more informal than those experienced elsewhere. The following comments were made by a woman recalling her first visit to the CSU.

Pat: I was very very suspicious about the place (CSU) I must say. But then I met one of the senior nurses and he didn't strike me as a professional sort of psychy person at all. I thought 'Who is this guy?' He was totally laid back, he had a sort of woolly jumper on and didn't come across as ... you know. I mean he had a nice smiley face, he was totally unassuming.

When asked about her past experience in the asylum, one young woman stressed increased friendliness and casualness as a distinguishing factor:

Anne: They (staff at the CSU) were always sort of more casual.... they (staff at the asylum) were much more stern in their attitudes and manners and less considerate and respectful really. Whereas they are more considerate and respectful in the community support unit....

She went on to compare the CSU with the DGH unit. In the former, staff were less formal and more 'casual'. This was mediated through an increased amount of time spent informally with clients.

Interviewer: You have already mentioned that the staff in the DGH were somewhat different to those in the old regional hospital, perhaps a bit more informal, whatever, less big brotherish. Again, how did the community support unit staff compare to the DGH unit?

Anne: They were nice, yeah. They were respective yeah, all right really yeah.

Interviewer: Were they very similar to the DGH unit or were they different at all in any way?

Anne: They were more casual than the DGH really.

Interviewer: In what sort of ways did that manifest itself?

Anne: I don't know ... because they had less patients to deal with, they weren't busy and they had more time for you really. But you get more individual time in the support unit than in the DGH because there are less patients, which was good really. They had time to talk.

This link between time spent with clients and the quality of the relationship emerged in the words of another woman. Here, however, she preferred her stay in the DGH unit.

Joan: They don't spend enough time talking to patients in the CSU compared with the DGH unit. Often there are two unqualified staff downstairs, domestics or something, and one qualified member of staff who spends the time upstairs.... In one ward (DGH) there are often three students available, so that it's mutually beneficial to talk. Also at the DGH they can go out for a walk with a student or go down to the bank, go down to the town, give them a lift – go to Bingo. I even went to Bingo once. The staff in the DGH are more sympathetic.

The fact that informality is mediated by available time for talking is important. It highlights the importance of structural issues and staff resources in determining the outcome of changes in the philosophy of care.

#### *Independence*

Another important characteristic of staff relationships in the CSU was the extent to which staff did not interfere with the mundane ways in which people organize their everyday routines. The following quote demonstrates this in two ways. Independence means that clients can come and go from the building and get up when *they* decide rather than when staff decide. This preserves autonomy and prevents institutionalisation.

Joe: I preferred the community support unit to the DGH unit ... more independence ... in the DGH you couldn't go out ...

Interviewer: So in the CSU they sort of let you go out down to the town?

Joe: Yes, as long as you let them know and all that, yeah.... that was the only thing that the support unit is a bit far from town, it's a fair old walk. I found that a bit of an inconvenience. If you could mix with the local people. Well, this time of the year it's very quiet there. But as far as the system goes there, I have got no qualms about it at all. You didn't have to get up at a certain time you know.

Interviewer: Is that something else which would have happened in the DGH unit?

Joe: Yes, if you wanted breakfast you had to be up at 8.30 am or something.

Similar points were made by a female client who had experienced both the DGH unit and the asylum.

Linda: I've been to [the old asylum], I've been to the DGH unit, and even the DGH unit I found difficult to swallow....

the DGH ... well, it's the better of the hospitals, put it that way, but it's the fact that they lock all the doors and they say it's for your own safety in case someone comes in. Who the hell are they trying to kid? Things like that really get on my wick, whereas at the CSU the doors are open all night, I mean if I want to wander out for a fag at 3 o'clock in the morning then I am quite welcome to or go down to the beach, so long as you tell the staff.

Limitations on freedom mediated the traditional paternalistic patient–professional relationship. On the other hand, the freedom retained by individuals at the CSU helped to preserve users' perceptions of their normality and rights in relation to staff.

Interviewer: I know this may seem like a stupid question but why don't you like being locked in?

Linda: Probably part of the problem is the fact that they are treating you differently. I mean even in an ordinary hospital once they find out you're a psychiatric patient they whisk you out of the ward so already you have a label – she's a nut, lock her up.

Independence also emerged when staff allowed clients to be on their own when they wanted, or, in the words of one resident, 'to allow you some physical and emotional space'. This recognizes the individuality of the person, and is in stark contrast to DGH units, where observation policies mean that patients have little privacy.

#### *Sense of equality*

This suggests that clients are treated as individuals in a normal relationship, rather than the 'traditional' relationship that exists between expert and lay person. The processes here are complex. For example, one woman said that she approved of the informal aspects of staff relationships and the sense of 'equality': 'Basically, it's nice to be on the same level as the patients and treat them as an equal'. However, this did not appear to conflict with the recognition of staff expertise.

Interviewer: I would imagine that if I was going through some sort of crisis it would be nice to have somebody who I felt was the expert because you get some security, I guess to some degree. Do you think at all that this more informal relationship ... that it means they are perceived as less of experts or ...?

Anne: No, not really no. You regard them the same really.

This suggests that 'roles' and 'relationships' are being separated. A traditional medical consultation is a meeting between two individuals in particular roles, expert and lay person. The interaction between the two, however, is not characterized solely by these roles, but also by a relatively formal relationship. It is not the meeting of two friends, *nor* is it the relationship which

might occur between two strangers. The conversation is purposeful, occurs in the doctor's territory, at the time the doctor states. The doctor has access to specialized discourse and knowledge, and is in control. An imbalance in power characterizes the formal relationship between doctor and patient.

For example, consider a traditional medical consultation between a GP whom the patient has never seen before, and the conversation that a man with backache might have with his partner who just happens to be a GP. Both conversations might achieve the same purpose but through different relationships between the parties. The former would be characterized by detachment and objectivity:

It is expected that physicians... restrict their work to the limits of their technical competence, work objectively, without emotional involvement, and finally put the patients' interests before their own (Friedson 1970, p. 159).

Clients' accounts of relationships in the CSU indicate that professional expertise is coupled with a normative, polite, relationship which has more in common with the interaction between friends than detached clinical relationships. Consider the following comments on her approval of a psychiatrist she had been seeing.

Liz: I must say the first couple of months I was there I enjoyed. There were some things that upset me of course ... Bob (a psychiatrist) used to take a keen interest in me, he used to come during my first stay and he looked after me in the DGH unit before I went there (DYC), you know. He used to bring photos with him. You just felt he gave you confidence and you felt he cared.

This arose by reducing the formality of the professional-patient relationship. The photos extend the relationship beyond what is necessary simply to fulfil a clinical purpose. This is, perhaps, a good example of what it means to be person-centred: to subsume the role of service provider/client within the social rules applying to a normative friendly relationship.

### **Role confusion and conflict with philosophical principles**

The principles of quality and partnership resulted in staff becoming less formal and more like friends. However, staff are more than friends; they are professionals with institutional roles and responsibilities to fulfil. This may bring them into conflict with the ideal of equality, and fractures the social rules which apply to the relationship between friends. To maintain partnership, the role of staff is minimized to that necessary to keep the unit operating. Consider the following extract from the annual report:

### **'Living the ideal'**

Partnership as a concept does not work unless people believe in it and demonstrate a commitment to it in their actions. In the CSU it is just as likely that the consultant psychiatrist will make a cup of coffee for a resident as vice versa. Another aspect of this is that staff are as supportive towards each other as they are to the residents.

Residents are as actively involved in the running of the unit as in planning their own treatment. Because there are only nursing staff and clients on the unit all the shopping, cooking and cleaning has to be planned and undertaken as a group activity between residents and staff (Murray *et al.* 1996, p. 4).

Cooking and cleaning are shared between staff and clients to avoid situations where one person takes charge and the other is subordinate. However, problems arise when role boundaries become blurred. The following is a good example. Here a young man consistently refused to participate in household duties, much to the annoyance of another client.

Linda: I remember in the end I said to one chap, I said 'Right, now I've had enough because you sit there and do nothing, you expect to be waited on, cooked for, you never wash up, you never Hoover, you never dust, you never do anything'. I said 'Right when I cook I don't cook for you' and I meant it. And I was cooking that night and down he came and said 'food', and I said 'No, no'. Then I found one of the members of staff plating up a meal and I went out after the member of staff and I said 'we are supposed to sort our own problems out; I've sorted it out, I've cooked, he doesn't eat what I've cooked, he can cook for himself'. And they said 'Yeah, but ...' and I said 'I don't care what's there, what's to eat' and I said 'well he can find himself something to eat because I'm not cooking for him and that's it full stop'.

Interviewer: And what happened then?

Linda: Well, the member of staff said there's no need to shout and all the rest of it and I said 'Look, I will shout at you if I want to, because you are interfering in something I have made a decision about personally'.

Here, there is a clash between the roles and responsibilities of staff members and the principles of equality and partnership. The problem for the staff member was to ensure the client receives food without damaging the relationship with Linda. The relationship with Linda was damaged because it revealed a latent authority which was exercised over her and her decision not to feed the man in question. The following is another example:

Liz: There was an admission arranged for me in October and he (psychiatrist) asked me how did I benefit from that, and I said 'NO', because there was a client there who really was crude and coarse and would talk with the care assistants. I mean I can take a joke, I like a laugh but I'm afraid when it comes to really low vocabulary and I found the care assistants lacking there. They should, instead of joining in with her ...

were playing up to her. Because they are there from different walks of life. Not everybody. I like a joke, as I said, but they were rather offensive.

The interesting point here is that the care assistants were criticized for behaving like any other person would in such a situation, but they were described as acting inappropriately because they were care assistants. This suggests that the client considered care assistants to be responsible for maintaining an acceptable milieu, and controlling behaviour which others might find unacceptable. A related issue concerned the expectation that staff should distribute their time fairly between clients. Some people commented that quieter clients sometimes lost out in the face of those who were more assertive.

Another problem arose from staff attempts to 'normalize' their relationships with clients by showing their feelings and discussing their own problems. Clients recognized that whilst there were benefits from this, there were also problems.

Bob: There are two ways of looking at it. If they (staff) say 'Yes, I understand because it happened to me' that's okay but if somebody comes and says 'Oh, bloody hell. This happened to me now'. Or if you are trying to explain something to somebody and they say 'Yeah, yeah, yeah ... the same thing is happening to me'. And every time they start talking about themselves, that you don't need ... they disregard you.

Staff attempts to maintain equality with clients conflicted with clients' perceptions of staff roles and responsibilities. The man above suggested that it was helpful to hear staff refer to their own problems, because it meant that these could be overcome and coped with, but the reporting of present problems was considered inappropriate by three people – 'it's a bit of a worry for the client'. The concern here is that the staff member may be unable to function effectively, making it more difficult for clients to raise their own worries.

## Conclusions

The type of staff–patient relationships required to provide a 'person-centred' service are complex. They are neither expert–lay person nor simple friendships. Elements of both exist. Clients generally approved of these relationships compared with those they had experienced elsewhere. However, there are conflicts between staff responsibilities and the unit's principles of equality and partnership. This points to a struggle that lies at the heart of the professional–service user dialectic. The nature of institutional power, roles and responsibility, place professional staff in conflict with the very notion of 'person-centredness'. The closest

theoretical model to the relationship described here is that of 'mutual participation' outlined by Szasz and Hollender (1956). The potential for internal conflicts within this relationship might only become clear when the individual professional–client relationship has to be managed within the context of a wider group in which the professional has both responsibilities and relationships. There are likely to be continuing problems in translating the theory of person-centred models into practice (Rossi & Freeman 1993).

However, the type of relationship required by 'person-centred' models may evolve as individual services attempt to deal with these conflicts. Resolution may be achieved from a compromise between the informal and expert–lay person relationship, based on equality and partnership, but moderated by the client's recognition of equity. This means that the relationship to be forged within a person-centred service must bring together the roles of patient, consumer and citizen. This points to the possibility of new roles and responsibilities (Chewning & Sleath 1996).

Despite this, there are serious obstacles to the full realisation of a 'person-centred' mental health service. Clients' comments reflect the problems which arise from the conflicts between staff responsibilities and informality, although they appear to value the latter. Attempts to provide services based on partnership demand changes in the roles of professionals and users. Winkler (1987) has commented that,

Partnership requires the medical profession to relinquish some of its independence and users some of their dependence. That is not an easy matter for either (p. 3).

All this points to the need to train psychiatrists in ways that attach as much importance to the politics of human relationships as to neuroscience. This study suggests that despite the current political value attached to 'partnership' (Executive NHS 1996), it will continue to be an elusive goal unless both staff and users explore the nature of their mutual dependence and independence. Partnership assumes concurrence. At present there seems to be few mechanisms to allow such explorations to take place.

Disagreements occur in all relationships and there are prices for both sides to pay. This leads to a paradox: patients criticize many features of the service yet they prefer it to the alternatives. The reasons for this contradiction require further examination, and this is consonant with the aim of empowering patients. This, coupled with the fact that the patient–staff relationship is less formal, may 'empower' patients to express their true feelings about the unit and to evaluate it critically. It is also possible that this shift in responsibility and power may increase levels of dissatisfaction with

services themselves (Meland *et al.* 1996) and reveal latent dissatisfaction (William *et al.* in press). Empowerment should result in higher levels of criticism, and the freedom to express this in those who use the service. This is not an area for those who seek a comfortable relationship with their patients. Neither is it a comfortable area for those concerned with more traditional measures of quality assessment and outcome. Attempting to implement a person-centred service challenges both the structure, process and desired outcomes of health service provision (Wakefield *et al.* 1994).

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