

The Familiar Stranger of Mental Health

An autoethnographical account of multiple and competing identities of a former patient, campaigner and service user.

Abstract:

Purpose- The paper contributes to the debate about the closure of institutional mental health care facilities, from an experiential perspective of a former mental health inpatient, ongoing service user and campaigner for retention of such facilities. It argues that auto-ethnographic accounts of mental illness by those with multiple social identities can have a greater role in terms of future training of mental health care professionals.

Design/methodology/ approach- The paper offers an experiential account of the impact of mental health facility bed closures as (a) a patient admitted to institutional mental health facilities; (b) as a mental health campaigner, fighting for the provision of both places of safety and 'safe space' within his own local community and (c) as an ongoing service user. The research is in the interpretivist tradition of social science in taking an autoethnographical methodological stance.

Findings- The paper is underpinned by two key theoretical notions. Firstly, Stuart Hall's concept of the 'Familiar Stranger' (2017) is used to explore the tensions of self-identity as the author uncomfortably between his three-fold statuses. Secondly the notion of 'ontological insecurity' offered by Giddens (1991) is utilised with the paper exploring the paradox that admission to a mental health so-called 'place of safety' is in fact itself a disorientating experience for both patient and carer(s).

Research limitations/ implications - No positivistic claims to reliability, representativeness or generalisability can be made. It is the authenticity of the account which the reader feels should be afforded primacy in terms of its original contribution to knowledge.

Practical implications - The paper should have practical utility for those tasked with developing educational and training curriculums for professionals across the mental health care sector.

Social implications- The paper implicitly assesses the political wisdom of the policy of mental health bed closures within the wider context of the deinstitutionalisation movement.

Originality/ value- This paper is underpinned by original experiential accounts.

Keywords- familiar stranger; ontological insecurity; self-identity; autoethnography; mental health institutional closures; deinstitutionalisation; place of safety; risk; training and education.

Paper type- Viewpoint.

Introduction

As I pick up the remote control to turn off the TV late one night, a Lloyds bank Mental Health UK campaign is on the screen. I'm being treated to a diet of celebrities as they sport yellow post-it notes on their foreheads. From the political and journalistic worlds there's Alastair Campbell and Jeremy Paxman respectively and the familiar face of Olympic cycling champion Victoria Pendleton. The post-its carry a range of mental health conditions which cannot be seen by those wearing them on their foreheads. There's everything from 'Stress' to 'Paranoia'. In carrying the hashtag 'GetTheInsideOut', recipients of the mental health labels face the camera and ask - "Am I going to live?"; "Could mind make me hurt myself?" and "Would they say that guy is nuts?"; are all articulated. After hitting the 'off' button and making my way upstairs I shake my head wondering how visible to others has the writing on my yellow post-it been today? How have my ruminatory thoughts been dealt with and self-managed? Have I felt the need to compulsively confess to anything to my colleagues at the University where I am employed?.

Unlike those who appeared in the advert, in many ways I wear not one but three post-its on my forehead for I am (1) a former mental health inpatient; (2) an ongoing service user and (3) an active mental health campaigner. Whilst I like to wear only one post-it at any given time sometimes I am unaware when one has dropped off my forehead onto the floor and at other times I'm not consciously aware that another yellow note has appeared above my eye brows. At various points in my life my forehead has become clustered as all three post-it notes have appeared messily, side by side or on top of each other. This has to be contextualised by my often contradictory attitudes towards deinstitutionalisation. This is a hugely contentious issue in mental health care provision because despite governmental promises of extra funding a significant number of mental health trusts have been forced to cut the number of acute mental health beds. In this context, Helm and Campbell (2018) pointed out that the number of hospital beds for people with acute mental health conditions, where a consultant psychiatrist is on hand as an overseer of treatment, has fallen by approximately 30% in the last decade (from 26,448 in 2009 to 18,082 in early 2018).

In exploring my attitudes to deinstitutionalisation, this paper is underpinned by two key theoretical notions. Firstly, the notion of 'ontological insecurity'. This concept is inextricably bound up with notions of our identity and a sense of stability. According to Giddens (1991: 92) "The phrase refers to the confidence that most humans beings have in the continuity of their self-identity and in the constancy of the surrounding social and material environments." It's critical to appreciate that as Giddens (1990; 1991) has pointed out, this cannot be merely reduced to a pathology of the mind- In drawing on the work of Erik Erikson (1965) on 'trust' in early childhood, Giddens acknowledges that whilst only a minority of people may be labelled as being mentally ill, it is possible that a significant proportion of the population are living with their sense of being and existence in the world being constantly challenged and undermined in late modern times. There is the constant threat of job losses; mortgage repayments; relationship terminations- to name but three things which add to our sense of social disorientation and this is when we are 'well'. When afflicted by mental health problems, in addition to the pressures of late modern living, it is not unreasonable to suggest that any remaining sense of ontological security is completely undermined and this is explore later in this paper.

Secondly, this paper employs Hall's (2017) notion of the 'Familiar Stranger', taken from the autobiographical account of the late cultural theorist Stuart Hall (2017), who acknowledges that the intellectual inspiration for this concept has in part to be credited to the work of the German sociologist Georg Simmel (1964). We will explore how the concept of the 'Familiar Stranger' perfectly encapsulates the fact that we all have multiple and competing identities of self.

The two pivotal concepts articulated above are a demonstration that in telling this story, my place in the social field is not clearly situated. I have multiple identities which are characterised by shades of grey rather than black or white and which blur at their boundaries. As I write I am very much a 'former patient' having twice in my life received institutional care. Secondly, I am also an ongoing service user of mental health care provision. I receive both medical and psychiatric support from both the state and the voluntary sector. Thirdly, I am an active mental health service campaigner who remains committed to attempting to improve safe space facilities in my home town in the absence of a place of safety under the mental health legislation.

Having introduced some key theoretical concepts and provided the context of debates over de-institutionalisation, a methodological account of the empirical approach to this paper needs to be addressed.

Methodology

Faulkner (2017) acknowledges the growing literature of 'survivor-led' research based on the experiential knowledge of former patients and service users. This tradition is underpinned by standpoint theory, as articulated by the likes of Harding (1993) and Tait and Lester (2005) in terms of the belief in utilising one's own specific social location as a starting point for an informed enquiry. This tradition is much broader than mental health research. Feminist standpoint theorists have, for instance, taught us much about how knowledge is socially situated and about how this social situation gives the marginalised the ability to ask pertinent questions in their research. (See for example Flatschart, 2017). A not dissimilar set of assumptions are held by those engaged in some aspects of disability research, such as de Bruin,(2017), who talks about the tension between traditional experimental based research and more recent and 'inclusive' methodologies.

In the mental health context specifically, much 'survivor-led' research focuses on autobiographical narratives which is not the explicit methodology used in this paper but the underpinning conviction that 'storied knowledge,' of the type alluded to by Weinstein (2010), Milligan et al. (2011) and Staddon (2013), should be of value in mental health research and practice is an implicit golden thread of this piece. Noorani (2013) contextualises this as the 'expert by experience' philosophy which gives equal primacy to 'experiential authority' compared with the 'traditional authority' of mental health professionals.

What this paper represents is in many ways a conflation of 'survivor', 'activist' and 'service user' discourses. According to Noorani (2013), as a response to the dominance of the medical model of mental health, 'survivor' discourses became

popular in the 1970s, with 'service user' perspectives following a decade or so later with the rise of the new public sector managerialism and consumerist discourses in public sector governance.

Rather than taking an autobiographical account, this paper utilises autoethnography. The 1970s witness the rise of this method, with the work of people like Karl Heider (1975) and Goldschmidt (1977). It was not, however, until two decades later in the 1990s, that the research practice became more accepted in academia due to what Adams et al (2014:8) refer to as an, "emerging appreciation for personal narrative".

At the heart of the ethos of autoethnography firstly, lies the belief that the personal perspective is central in understanding specific cultural experiences. Secondly, this method rejects some of the knowledge claims of more positivist epistemologies in terms of the idea that reality is 'objective' and waiting to be discovered. The approach gives primacy to the subjective because it is underpinned by the more interpretivist notion that the world is a social construct. Thirdly, the method is very much value-centred rather than claiming to be value-free. (See Holman Jones et al. 2016)

So having outlined a methodological approach, let's turn now to my own journey of compulsion.

A compulsive journey

My diagnosis in 2003 as suffering from clinically defined Obsessive Compulsive Disorder- the so called 'Doubting Disease' (Cefalu, 2010), is central to this research. As someone who suffers from a rare form of confessional OCD (see Kennemer, 2007), I was first admitted a place of safety in 2009. So my use of the 'telling' method of autoethnography is born partly of hope that others can find meaning in my struggles. My experiences as a mental health inpatient, service user and campaigner are intertwined with my academic orientation and for the autoethnographer this is part and parcel of accepting that, "our lives and experiences are intertwined with our research projects and participants." (Adams et al.; 2014: 9). Coping with OCD and the manifestations of its anxieties, compulsions and rituals has become a way of existing just as autoethnographic accounts should be, "more than a research method" because they too are, "a way of living" (Adams et al.: 20). (13) In acknowledging the intellectual influence of Romanyshyn (2007), Robertson et al. (2017) borrow the term the 'wounded researcher' and utilise vignettes to articulate lived experience. The notion of my having multiple identities may not be the norm but there are others who have utilised autoethnography to reflect on their own diverse experiences. Liggins et al. (2013) for instance, in writing about places of healing is able to reflect critically on her multiple roles as compassionate observer, service-user and mental health care professional.

I was treated for my OCD at The Margaret Stanhope Centre in my home town of Burton-on-Trent, starting off my treatment as a voluntary patient in January 2009 but when I became acutely ill and was sectioned several weeks later after being perceived to be at risk of harming myself. One year after I was discharged in the Spring of 2009, the South Staffordshire and Shropshire Healthcare NHS Foundation Trust announced consideration of closing the centre as part of a strategic review of mental health care provision. At this point, as a former patient of the facility, I was encouraged by fellow

former patients and their carers plus some staff at the facility to launch a campaign group attempting to keep the facility open and thus the 'Friends of Margaret Stanhope Forum' was launched. At the conscious level I did this on a voluntary basis in good faith but upon reflection I have often wondered whether subconsciously I was using this as an opportunity to improve my feelings of self-worth and social status through galvanising my social capital and through activism which was resulting in public approval from those in my community.

So my in autoethnographical journey is not of one but three selves. To explain this one has to go beyond the notion of 'cognitive dissonance' – a reductionist concept which assumes that self-identity can and perhaps should be fixed and coherent. A more sociologically informed concept which would allow for the co-existence of the multiple identities which characterise my existence would be the notion of the 'Familiar Stranger' Critically, Hall (2017) observes that self-identities are constantly evolving, shifting and that this is as much a change in social process and context rather than a dissonance of the mind. Whilst my autoethnographical account will inevitably be fragmented and 'messy' as is life itself, this is something to embrace according to Adams et al (2014:9) who have argued that, "we must embrace a research method that, to the best of its/our ability, acknowledges and accommodates mess and chaos, uncertainty and emotion". By sharing my own experiences in this account I am in turn hoping to be able to appeal to others beyond my own 'lived experience'. (See McIntosh and Wright, 2018).

Autoethnographical research by academics who have experienced mental health problems is certainly far from unique as Campbell (2018) alludes to in her narrative about recovery from depression. Likewise autoethnographical research embarked upon by those suffering with OCD, like myself, is not altogether new as is one can see with the work of Brooks (2011: 251) who cites the contribution of Behar (1996) in terming this style of academic practice as, "writing vulnerably". She does this in order to explain struggle offer an insight into how the manifestation of the illness involved a pendulum swing between public performance and compulsive private behaviour. I am therefore writing from a relatively disadvantaged standpoint as someone whose history of mental illness indicates a vulnerability in terms of involuntary detention in the future but I have alternative statuses which this paper will explore.

So now let's turn to my own autoethnographical accounts which involve those contradictions between my three identities.

Identity as Former Patient

August 2018 saw the devastating news that my mother was terminally ill with cancer. Almost immediately I could not sleep at all for days on end and I was barely able to eat- my body had gone into a state of shock. Three weeks or so later I was in need of institutional mental health care. Upon arrival at the George Bryan Centre in Tamworth in September 2009, despite being accompanied by my partner and her eldest son, I was too disorientated to know what possessions I had with me. I was, however, made aware that some of these possessions would be confiscated. As my partner revealed that I suffered from a confessional form of OCD, my mobile phone was locked away, for fear that I may make inappropriate phone calls to those in positions of authority,

such as the police or my employer. As well as this measure to protect my reputational safety, in order to ensure the risk of self-harm was minimised, I was made to remove my trouser belt, for fear I may have hung myself. I recalled the same feeling of dread wash over me as I had when upon being admitted to the Margaret Stanhope Centre almost a decade earlier in 2009. Back then, I was promptly asked whether I felt safe and then reassured that I should feel “safe”. My lay knowledge of OCD leads me to believe that this was a well-intentioned mode of reassurance from a highly ethical and caring mental health care professional. This being said as a mode of reassurance this ‘check’ that I felt safe served to inadvertently feed my insecurities and led to compulsive and self-harming behaviours. Over the next few days and weeks I drove my fingernails into my forehead causing my head to bleed and I needed medical treatment for this self-inflicted wound.

A decade or so later in Tamworth, my daily routine of existence was shattered upon entry to the hospital and this is something which goes to the very heart of the issue of ‘ontological insecurity’. Within hours of my admission to hospital in Tamworth in 2018, I became acutely aware of my practical insecurity. I feared physical victimisation from one or two male patients and began to experience what I perceived to be harassment from a young female in her early twenties, who had an eating disorder. I was followed everywhere by this female around the ward, even when I took myself to the end of the corridor to make private calls from a phone booth to my partner back at home. When my partner visited me, the young female concerned invaded our personal space and sat staring at her causing my partner to fear that she was just about to be physically attacked. Several weeks after admission, I began to be followed in a not dissimilar way by an older woman with a personality disorder, who was under section and who disclosed to me that she had found out my partner’s surname. This heightened my own anxiety about future visits from my own partner in terms of her own safety.

My feelings of insecurity were exacerbated due to my fear of victimisation in terms of property theft. During the early phase of my month of hospitalisation I had no key to my room so was unable to lock my door. A fellow patient had complained that his clothes had gone missing from his room which was close to mine and when I checked my wardrobe, I believed my own clothes had been stolen. Feeling anxious and insecure I reported the ‘theft’, only to discover several hours later that my partner had in fact taken them home to be washed.

As well as the fear of victimisation, in terms of Maslow’s (1954) hierarchy of needs, I was insecure about the apparent lack of food on the ward. There seemed to be a scarcity of the daily sandwiches at tea time. Despite my clinical depression, I seemed to be extremely hungry during the weeks I spent on the ward and lost over a stone in weight. According to Giddens (1991: 98), “The predictability of the (apparently) minor routines of day-to-day life is deeply involved with a sense of psychological security.” At this point there was no identifiable ‘predictability’ because I was not used to the ‘new’ routine. There was also a rumour on the ward that there was a lack of medication. This sent my anxiety skyrocketing as I was in a catatonic state of insomnia and believed that sleeping pills were my only hope of being able to get some kind of sleep. My insomnia was trapping me in a vicious circle of being anxious about not being able to sleep, and this lack of rest was in turn causing a heightened sense of anxiety. This

is once more characteristic of 'ontological insecurity. According to Giddens (1991: 98), "When such routines are shattered— for whatever reason— anxieties come flooding in, and even very firmly founded aspects of the personality of the individual may become stripped away and altered".

What is interesting is that on both occasions in my life that I have received institutional mental health care provision as an inpatient both my mother in 2009 and my partner in 2018 reminded me that, "You did everything you possibly could to get out of that place".

So having spent so much time attempting to 'escape' institutionalisation it's worth addressing why I then spend a significant proportion of my time campaigning for the retention of those very institutions.

Identity as campaigner for retention of mental health places of safety

Back in October 2011 South Staffordshire Primary Care Trust launched a 3 month consultation on plans to close the centre and this intensified the efforts of campaigners, with the local newspaper 'The Burton Mail' launching the 'Save Our Stanhope' campaign, which both the Friends of Margaret Stanhope Forum supported, as did the local MP and a range of local councillors of all party persuasions. (See <http://www.burtonmail.co.uk/.../Save-our-Stanhope-25102011.htm>)

One of the criticisms we endured as a patient led protest group was the accusation by NHS management that we were unhealthily fixated in place rather than quality of service of mental health delivery. Whilst refuting these suggestions, in my private moments I often questioned whether subconsciously, there may have been an element of truth in these challenges. Could it be that someone with a mental health condition like myself, had a need to be able to point to a physical place of safety in my own home town simply because it was identifiable, tangible and concrete- a kind of safety blanket which I needed to have to satisfy the demand for future certainty and security which my OCD was calling for if I became acutely ill in the future? NHS management were telling us that place and structure were no longer the issue but rather quality of service was paramount.

One of the concerns raised by protestors including myself during the 'Save Our Stanhope' campaign was that mentally ill patients from Burton-on-Trent who needed institutional care, would increasingly be transported to The George Bryan Centre in Tamworth (where I would be treated almost a decade later). Tamworth's institutional facility was approximately 17 miles and at least a 30 minute drive away. Campaigners argued that it was not unreasonable to assume that a good proportion of patients and their carers would have no alternative but to use public transport. Whilst on paper a train journey time between Burton and Tamworth looked an attractive proposition at just 11 minutes, it was noted that the train station was just over 3 miles away from the George Bryan Centre itself, which would mean additional costs would have to be

incurred with a taxi ride. In terms of alternative modes of public transport, campaigners noted that there was no direct bus service between Burton and Tamworth.

Back in 2009, when hospitalised in the Margaret Stanhope Centre which was less than 2 miles from my home in Burton-on-Trent, I received daily visits from both of my parents. What seemed to facilitate my recovery after several months was a gradual, phased release back into the community. This began with being allowed off site for an hour to walk round the local recreational fields with my father and continued incrementally into four hour releases where I went home to be with my mother and father and then eventually was allowed overnight release, before eventually being discharged. My hospitalisation almost a decade later in 2018 was a somewhat different experience. The hour long round trip to Tamworth meant that my partner simply could not see me every day in balancing her work commitments along with my care. Her visits every few days involved snatched moments of conversation in the kitchen on the ward or in the garden at the George Bryan Centre. The kind of phased return which I had found beneficial when being treated in my home town back in 2009, was simply not the same a decade or so later due to logistical problems and travel time to and from the ward. As noted by Salisbury et al. (2016) this move to deinstitutionalisation has been supported by those who bemoan the dehumanising effects of being in a Goffman (1961) like 'total institution'. As a patient I could relate to this but as a campaigner I was denying to both myself and others that I had found my experience to be dehumanising.

My 'campaigner' identity presents a public face and local media image which is underpinned by the appearance of a firm conviction that I am a 'pro' the retention of both places of safety and 'safe space' facilities. By contrast, my identity as former patient is characterised by feelings of ambiguity over the value of institutional mental health care. Hall (2017: 16) provides insight with his observation that, "identity is not a set of fixed attributes, the unchanging essence of the inner self, but a constantly shifting process of *positioning*". This notion of positioning is important because from a lay perspective I think that much of this occurs at the subconscious level. This is what Hall (2017: 210) conceptualises through the notion of, "unconscious modulations". It's not something I have been cognisant of. Indeed if I were overtly conscious of it, I would be open to the charges of insincerity, duplicity and bad faith.

The waters become even more muddied and murky when one introduces a third identity- this time not patient nor campaigner but 'service user'.

Identity as Service User

I have always struggled with the notion of being a 'service-user' because it's a term which I associate with the New Right reform of the public sector as articulated by Clarke and Newman (1997) in accounting for the shift from a welfare to a managerial state. As a mental health campaigner I used to deliberately mock the use of the term when it was used by NHS management to argue that the mentally ill were no longer passive recipients of treatment but active 'consumers' who had a degree of choice. "Who chooses to be mentally ill in the first place?!" I would ask, deliberately invoking humour to provoke a supportive reaction from fellow campaigners and the public to try and 'Save Our Stanhope'.

Once again this reveals yet another fracture in terms of my self-identity. As I had done when hospitalised in the Margaret Stanhope Centre in 2009, I spent most of my time in the George Bryan Centre in 2018 trying to think of how I could get myself released from the very type of institution which I had campaigned so vehemently for! At that point I would have given anything to be a service-user being treated in the community rather than an inpatient.

Upon discharge from the George Bryan centre, one month after admission, I received a visit from a social worker and psychiatrist. I was put in touch with the Horninglow clinic who monitored my wellbeing for several months. To this day I am a service-user in terms of having the ability to choose which counselling courses I wish to register for in terms of ongoing support and I remain very much a patient in terms of being administered prescribed medication for depression and anxiety by my GP. So how can my willingness to embrace my status as 'service-user' be squared with my mocking of that very term whilst wearing my campaigning hat? The notion of 'hypocrisy' is too reductionist and censorious a narrative to buy into and these contradictions need detailed discussion. So let's now turn to trying to make sense of the contradictions of these multiple and often competing identities.

Discussion

The American sociologist William DuBois (1903) popularised the notion of 'double-consciousness' at the beginning of the twentieth century. More than one hundred years later Hall (2017: 140) has spoken of those who feel a sense of "belonging to more than one world". This is precisely my experience when moving between the planets of former patient, campaigner and service user. Hall (2017:16) continues that, "identity is always a never-completed *process* of becoming- a process of shifting *identifications*, rather than a singular, complete, finished state of being" and are therefore set in many ways, "in antagonistic positions". (2017: 144) This failure to achieve what Hall (2017: 144) refers to as an "essential identity", is far more than just a shift between personality states and that's why although I do manage a long term mental health condition, namely OCD, it would be misplaced to pathologise issues of identity which have a profoundly social context.

Hall (2017: 23) encourages us all to accept that, "Identity is never singular but is multiply constructed across intersecting and antagonistic discourses, practices and positions". So in this sense we have to learn to accept that we will inevitably feel insecure as we shift between our multiple identities. At this point we can begin to link this sentiment with the aforementioned notion of 'ontological insecurity'. (Giddens, 1991). My identities are in a constant state of reconstruction, thus I cannot achieve ontological security. When consciously mobilizing my identity from former patient to campaigner, for example, my identities become problematized and there is inner discomfort. Hall (2017: 144) argues that, "No identities survive the diasporic process intact and unchanged, or maintain their connections with their past undisturbed". Whilst the term 'diaspora' is ordinarily used to refer to displaced or scattered populations in migrant terms, in my own context it is my sense of secure self which has been scattered as I constantly travel the social distance between patient, campaigner and service user on my circular journey. So for me it is not so much a

geographical scattering or dispersal but a social dispersal. Setting my campaign work aside, anyone who, like myself, experiences the daunting process of transition from inpatient back to outpatient will experience this in terms of how to renegotiate one's sense of identity back into the private sphere or a household and family membership and the public sphere of work and one's social life. My transition from inpatient to outpatient, for instance, signalled the beginning of the end of my three year marriage and I was once again a proverbial 'single man'.

The key is that there may be much that practitioners can learn from my diasporic experiences.

Implications for policy and practice

This paper continues to raise questions over the wisdom of de-institutionalisation which is in the realms of the political elite and policy makers, at the macro level of decision making. Whilst the government and health care providers have to consult with service users when planning and evaluating mental health care provision, perhaps a more immediate and realistic impact of practice would be to encourage a more prominent place for autoethnographic and experiential accounts of mental illness which could inform the training and development of mental health nurses, medical and psychiatric practitioners. At the 'meso' level, these practitioners 'manage upwards' their concerns over deinstitutionalisation to NHS policy makers and the wider political elite. The work of Kortteisto et al. (2018) articulates a growing global trend towards greater service user involvement in mental health care provision. So my call for the use of autoethnographic accounts from former patients, campaigners and service users to inform the training of mental health care workers is a realistic one. This being said it is likely to be met with at least some degree of resistance. From my own experience just because someone works in the mental health field does not mean that they themselves are not susceptible to holding some stereotypical and prejudiced views of the kind traditionally associated with wider society. During my institutionalisation in 2009 for example, I was informed that a group of former patients had expressed a desire to visit the facility and to talk to us current patients in an attempt to give us the proverbial emotional 'lift'. In bemoaning this initiative, a mental health nurse said directly to me, "This is like letting the lunatics take over the asylum". Inappropriate sentiments such as these should be contextualised with reference to Kortteisto et al's (2018: 686) point that, "Mental health services have a history of containment, compulsion and stigma which may hinder the changes in culture and attitudes towards service user involvement". If cultural resistance can be overcome, Autoethnographical accounts such as the one provided here have a small but significant part to play, with former patients and service users making a contribution as, "lived-experience educators" (Kortteisto et al. 2018: 686). We need to find spaces for former patients, service users and campaigners to help with the design, delivery and evaluation of mental health nursing training for instance- they should be encouraged into visiting fellowships, associate lectureships and external examiner panels in higher education.

Policy and practice has to be evidence based and part of this is signposting towards future research in the field.

Future Research

Academics from all disciplines have an invaluable role to play in terms of informing future policy debates about deinstitutionalisation as well as contributing to the training of mental health care professionals. Academics have an invaluable role to play through autoethnographical accounts because as a collective, they will be invested with the kind of cultural capital (Bourdieu, 1986) and ability to be reflexive about their own experiences whilst at the same time being able to locate these experiences in broader social contexts. Hall (2017: 144) makes the call to, “think of yourself as diasporic” and I would appeal to academics to write as themselves of diasporic beings as patients, campaigners and/ or service users.

Conclusions

I have long struggled with my ‘real’ feelings about whether institutional mental health care provision is a good or a bad thing and this is precisely because of my different positions in the field. This paper is part of my ongoing journey towards acceptance that my self-identity will never be complete in. I remain what Hall (2017: 172) terms, “an uneasy traveller” between my three identities. I am, however, more accepting that, “the imperatives of identification are perpetually paradoxical”. (Hall, 2017: 22). This submission is therefore a viewpoints paper in the plural rather than a viewpoint perspective in the singular. What Hall (2017: 172) has termed the “diasporic perspective” has the opportunity to provide, “a new vantage point, since by definition diasporas imply more than one positioning”. The real learning which papers like this have to offer lies in exploring these very contradictions which a dispersal of scattered identities can contribute to the debates on mental health care in the future..

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