Chains of (dis)trust: exploring the underpinnings of knowledge sharing and quality care across mental health services

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Abstract: Quality and safety in healthcare settings are underpinned by organisational cultures, which facilitate or impede knowledge refinement, sharing and application. Avoiding the use of 'culture' as a residual category, we focus specifically on describing chains of (dis)trust, analysing their development across relatively low trust service contexts and their impact upon knowledge-sharing and care giving. Drawing upon data from in-depth interviews with service-users, professionals, service managers and other stakeholders across three mental healthcare (psychosis) teams in southern England, we identify micro-mechanisms which explain how (dis)trust within one intra-organisational relationship impacts upon other relationships. Experiences and inferences of vulnerability, knowledge/uncertainty, interests and time, amongst actors who are both trustees and trusters across different relationships, are pertinent to such analyses. This more micro-level understanding facilitates detailed conceptualisations of trust chains as meso-level tendencies which contribute to wider vicious or virtuous cycles of organisational (dis)trust. We explore how knowledge-sharing and care giving are

vitally interwoven within these chains of trust or distrust, enhancing and/or inhibiting the instrumental and communicative aspects of quality healthcare as a result.

Keywords: trust chains; knowledge-sharing; quality; psychosis services; vulnerability; time.

Introduction

Effective 'learning organisations' facilitate the refinement and efficient circulation of high quality practices, while identifying and applying lessons from contexts or incidents where adverse consequences are experienced (Department of Health 2000, Walshe 2003, Sheaff and Pilgrim 2006). Numerous policy interventions in the English NHS, where the current study was located, have sought to enhance quality and safety (eg Department of Health 1997, 2005, 2008), often focusing on organisational communication and knowledge management, but with mixed outcomes (Alaszewski 2005, Waring 2005, Sheaff and Pilgrim 2006, Dixon-Woods et al. 2014).

Informal organisational cultures are fundamental to understanding quality and safety practices in terms of information sharing (Waring and Bishop 2010) and the impact of quality governance (Waring 2007, Brown 2011). Ormrod (2003), though, denotes the danger that 'culture' becomes a vague residual epithet, under which policy-makers and analysts categorise organisational phenomena lying beyond their control and comprehension. In this study we explore very specific features of organisational culture – interwoven relations of (dis)trust across organisations –

which bear fundamentally on the communicative and learning functioning of local healthcare services. Far from capturing all of organisational 'culture', our analysis nevertheless identifies salient processes which help explain important 'patterns of relationships and meaning' (Ormrod 2003: 230) across organisations and beyond.

Our analysis functions in between, and thus connects, the 'facework' of (dis)trusting interpersonal interactions and broader cultural tendencies towards (dis)trust, communication and learning (Davies and Mannion 2000, Sheaff and Pilgrim 2006, Calnan and Rowe 2008, Authors). Such connections, developing theory around trust as a 'meso-level concept' (Rousseau et al. 1998:394), have been neglected, especially in studies of health policy and sociology (Gilson et al. 2005) but also within organisational studies. Across these fields, a dualism exists between more '*sui generis*' analyses of dyadic relations, largely independent of context or employing poorly operationalised understandings of how context is influential (Cook et al. 2004:66), and studies of more diffuse networks of actors and organisational systems which lack specific mechanisms for explaining shifts towards (dis)trust (Tan and Lim 2009).

Trust has been seen as fundamental for quality healthcare provision and outcomes across many national and local healthcare contexts (Mechanic and Meyer 2000, Dibben & Lean 2003, Sheaff and Pilgrim 2006, Calnan and Rowe 2008, Brownlie 2008**),** enabling action, cooperation and knowledge sharing where these are otherwise problematic (Adler 2001). Existing empirical research indicates possible linkages between different relationships (see especially Gilson et. al 2005): whereby

manager-professional trust shapes 'workplace trust' and cooperation between professionals; where the resulting inter-professional trust impacts on trust building activities between clinicians and patients which, in turn, shapes quality of care (Gilson et al. 2005); or more broadly where quasi-external governance arrangements, based on policy-makers' apparent mistrust of doctors, may lead to the development of 'structures, policies and processes' (Gillespie and Dietz 2009, Cook et al. 2004) which support and/or stifle the communicative cultures through which trust and organisational learning are generated (Adler 2001; Sheaff and Pilgrim 2006).

The impact of broader policy-organisational structures and related managerial priorities may be especially strong within English NHS mental healthcare – especially services for patients diagnosed with psychosis – where 'risk management' has become a defining policy goal and consequent organisational preoccupation (Langan, 2010) and where public sphere depictions of services have emphasised poor quality (Burns & Priebe, 1999). Policy frameworks may therefore be effectual not only in structuring workplace interactions (Gilson et al. 2005), but impact more directly on trust by influencing how the competency and interests of professionals and managers are considered, respectively, by users and professionals (Giddens, 1990, Warner 2006, Calnan and Rowe 2008).

Theoretical framework: trust chain*s*

Theoretical understandings of the interlinking of different trust relationships across healthcare settings remain nascent and largely descriptive (Gilson et al. 2005). Analyses can be thickened through phenomenological insights – in recognising the

extent to which interactions are characterised by inferential interpretations of proximal or more distant others (Schutz 1972), in light of more explicit or implicit understandings of the policy priorities, rules and organisational dynamics of wider 'abstract systems' (Zimmerman 1971; Giddens 1990, Gillespie and Dietz, 2009, Acemoglu and Wolitzky 2012).

The working definition of trust applied in this paper accordingly follows Möllering (2005; 2006), amongst others, in focusing on interpretations and assumptions of compatible agendas or interests, alongside the bracketing off of doubts, which enable positive expectations and thus cooperation regarding a future outcome, amidst vulnerable and uncertain circumstances. The trustee must also be inferred as sufficiently capable to bring about positive outcomes (Das and Teng 2001) – hence interests and competencies are two fundamental pillars of trust (Calnan and Rowe 2008).

The salience of inferred interests for trusting relation

Within organisational studies of learning and effectiveness within knowledge-intensive environments, Adler (2001) denotes three bases of trust which are instructive for conceptualising how interactions and priorities in one relationship influence trust-building and thus information-sharing activities elsewhere: familiarity, calculation of the interests of others, and awareness of binding norms and values. These three bases form useful empirical foci for describing interdependent trust relations: where changes to trust (or its alternatives where trust is limited) within one relationship (eg manager-professional) impact upon

communicative interactions across other relationships (eg between professionals) –
changing levels of familiarity, interpretations of converging or diverging interests, or
where shared norms and values may be interpreted as becoming more or less
binding – then (dis)trust within these other relations is likely to be impacted as a
result.

Drawing on phenomenology and ethnomethodology, Möllering (2006:57) indicates
the complimentarity of familiarity, calculated interests, and compatible norms and
values when arguing that interpersonal trust is not so much dependent on the
individual trustee herself as by the existence of certain social norms and values in
which this trustee's actions are embedded. Such constraining normative structures
render a trustee's future actions more 'predictable' (Möllering 2005:292), in contrast
to what we might call loose cannons. Greater levels of familiarity mean the truster
presumes a deeper understanding of the social norms and values (institutions)
which bear upon the trustee and her degree of embeddedness within these
(Zimmerman 1971). This leads the truster to interpret a more reliable 'calculation' of
the trustee's interests and likely behaviour – facilitating (dis)trust.

Emphasising the salience of normative contexts for trust (Möllering 2005) draws our
attention to two fundamental environmental features of modern-bureaucratic
healthcare: *instrumental* bureaucratic pressures towards rendering healthcare work
consistent, verifiable and evidence-based may potentially compliment or impinge
upon more *communicative*, person-centred processes focused upon shared
understandings and consensus-building (Habermas 1987). Where a manager or

professional trustee (for example) is interpreted by a potential truster as being insufficiently embedded within the instrumental and/or communicative, or rather too embedded in one and not the other, then trust becomes problematic (Brown 2008). Policy changes, at healthcare system and/or local organisation levels, may also be interpreted as indicating a shift in the structuring of individual interests towards the instrumental/strategic or the communicative – accordingly assisting or undermining trust.

Interests, vulnerabilities and uncertainties as lynchpins in (dis)trust chains

Interests and norms are central in explaining possibilities for trust but are also decisively shaped by trusting contexts (Dirks and Ferrin 2001) and by the bureaucratic 'checking' that takes place within organisations in the relative absence of trust (Davies and Mannion 2000). Changing forms of trusting or checking within one relationship are likely to influence the day-to-day behaviour and interactions of the actors involved (Calnan and Rowe 2008). These modifications, in turn, may have important implications for the (interpreted) interests of these actors and the continuing compatibility – or incompatibility – of their interests with those of other actors within other relationships.

Figure 1

The position of various actors, particularly (manager-)professionals, as both trustees (within one relationship) *and* trusters (within other relationships) is crucial to the generation of chains of (dis)trust across organisations, as are their experiences of, and responses to, vulnerability amidst uncertainty (as summarised in figure 1):

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Vulnerability and uncertainty make trust necessary (Möllering 2006), are transformed through trust – where trust offers a solution to vulnerability while the actor also becomes more vulnerable when trusting – and exist in heightened levels when trust is lacking. An actor's solution to this changing vulnerability amidst uncertainty will be new forms of more communicative and/or instrumental action – such as voicing and sharing concerns with other actors (communicative), or resorting to checking, evasive or defensive practice (instrumental/strategic) – as oriented by whether she feels trusted or not, alongside the norms and envisaged possibilities of her culture and identity and the demands imposed on her within social contexts (Habermas 1987). More communicative action may heighten familiarity and knowledge sharing which, as argued earlier, is relevant to trusters' presumed knowledge of the interests of trustees (Adler 2001). More strategic and bureaucratic behaviour, alternatively, may impinge detrimentally upon relations and hinder familiarity, as well as stifling learning.

That these key concepts of interests, vulnerability and uncertainty, are each influential upon, and outcomes of, (dis)trust make them vital lynchpins in explaining chains of (dis)trust and thus the broader virtuous and vicious 'cycles' which Gilson and colleagues (2005: 1427) tentatively point towards and which have been observed in organisational studies (Ostrom 2005; Bevan and Hood 2006).

Effective and detailed analyses of micro-level mechanisms through which cultures of trust or distrust propagate are vital to sociological studies of quality and safety due to the multifarious ways in which trusting relations underpin quality healthcare

practices both directly, as a component of quality patient experiences (Calnan and Rowe 2008), and indirectly through facilitating: patients' sharing of information (illuminating needs and appropriate care) (Brown and Calnan 2013); the flow of knowledge within healthcare organisations (Sheaff and Pilgrim 2006); the development of other capabilities to meet needs effectively and efficiently. The analysis below explores the mechanisms of such linkages between different trust relationships and their interwovenness with interpersonal communication, organisational learning and quality care.

Methods

Approach and design

Conceptualising trust as a process involving the sense-making experiences of actors and the way these are drawn upon when inferring knowledge about actors, groups and organisations (Gillespie and Dietz 2009) suggested the utility of a phenomenological approach, which informed research design, interviews and data analysis. The taken-for-grantedness (Schutz 1972) in which trust processes are embedded renders them difficult to research, hence Bijlsma-Frankema and Klein Woolthuis (2005) suggest the utility of studying trust in destabilised contexts. The experiences of psychosis service-users, professionals and managers all involve unusually heightened uncertainty and vulnerability. These mental health services thus constituted low trust environments (Pilgrim et al. 2011) yet researching three contrasting services granted some variation in trust dynamics. These were purposively selected in order to explore the varying extent, nature and relevance of

(dis)trust across different team and care dynamics. Trust relations and their effects were explored across these three sub-cases – 'early intervention' and 'assertive outreach' services, alongside a more standard community mental health team, all within one NHS Trust (local health authority) in Southern England – through semi-structured interviews with service-users, professionals and managers (n=21). Interviews with a carer and area chaplain were used to further deepen understandings.

Sampling and participants

Table 1 provides an overview of the professional and manager participants per service. Some of the professionals had considerable experience although this varied (mean=16.1 years working in mental health services, SD=10.6). Recruiting service-users (8 users and 1 carer targeted per service) proved much more problematic. Inclusion criteria were service-users aged 18 and over, while only those who were experiencing a more acute phase of their illness were excluded. Despite a number of different recruitment strategies and distributing invitation letters to 158 participants, only 8 service-users (see table 1) were interviewed.

Table 1

Service-user participants nevertheless reflected a diverse range of backgrounds and experiences (mean duration of contact with services = 15.9 years; SD = 12.4), spanning sex (4 men,4 women), age range (from 25 to 67), education levels (from leaving school at 16 to post-graduate study and increments in between) and economic activity (out-of-work; voluntary work; paid-part-time work; retired). Two

had less than 2 years contact with services while the remainder had at least ten years experience.

The very low response and sample bias make it likely that the trust problems our data indicate may in fact be much more profound, especially among certain ethnic minority groups who were absent from our sample (Appleby 2008). This latter limitation, alongside broader recruitment problems, may reflect the vulnerability of the sample population, the practical and ethical difficulties associated with this (Smith 2008) and the limited capacity to adopt a more flexible recruitment strategy due to NHS research-governance bureaucracy. When initial attempts at recruiting users via services were unsuccessful, adjustments to access protocols took several months to be endorsed which, when combined with the deadlines of the research-funder, limited possibilities for pursuing and experimenting with different tactics. Our distance from potential user-participants within the recruitment process, having to contact participants by letters mailed out by the services, means we can only speculate on reasons for low-response. One lesson emerging from these experiences would be the desirability of contacting service-users through networks of users (more organised and/or informal) rather than through NHS services themselves. These alternatives would limit dependence on NHS research-governance and more importantly limit the possible contamination of the research from low trust organisations.

Data collection

Interviews with staff typically lasted 30 minutes to one hour and were thematic in format , addressing issues of working with and relating to service-users, how positive outcomes were pursued, and challenges of the job. As with all the interviews, although trust was the central focus of the research, direct questions regarding the concept were sequenced towards the end of the interviews in order to examine the relevance of trust as it emerged 'naturally' within participants' accounts. Later questions then probed different (dis)trust relations and the nature, influence and/or extraneousness of trust.

Service-user and carer interviews followed a longer (50mins-1h45), more narrative format, accessing broader contextual experiences which influenced trust and considering the development of trust/distrust as processes which changed over time in their depth and nature (Möllering 2006:153). Emerging themes were revisited towards the end of the interview, along with key questions which had not emerged initially within the narratives. The study attained local NHS ethics committee and research governance clearance. Interviews took place throughout 2010.

Method of analysis

Interview recordings were transcribed, read multiple times and coded (within N-Vivo). Basic coding was carried out after each interview in order for emergent themes to inform later interviews. Coding involved open, axial and selective stages (Neuman 1997) – by which 'open' refers to identifying a broad range of potentially relevant factors, partially sensitised through the phenomenological approach outlined above which directed attention to apparent assumptions and meaning-

constructions of participants (Smith and Osborn 2003). Axial coding used the ongoing (re)delineation and (re)connection of events and concepts into a more coherent framework, highlighting recurring and salient processes and linkages.

These more developed understandings were then further refined and nuanced through 'selective' application across individual accounts and events, paying particular attention to deviant cases and the implications of these for overall interpretations. The triangulation of managerial, professional and user insights into different relationships (Cook et al. 2004), especially in light of differing dynamics in each of the service sub-cases, aimed to augment internal validity in developing theoretical insights out of a case-study approach (Eisenhardt 1989). To this end we paid much attention to the various participants' narratives about different relationships – with specific individuals and more general views – with(in) the organisational context as these had developed over time, as well as considering sense-making of local service contexts and the NHS more generally. Double-coding and critical discussions around the coding process between the researchers and other academic and clinical colleagues assisted the interpretive rigour of the analysis.

Findings

The data presented below illustrate predominant themes emerging within the analysis, while also acknowledging differences and nuances between sub-cases (services). We particularly focus upon various antecedents and consequences of trust in identifying chains of (dis)trust as these stretched from policy-makers to service-users.

Quality and performance governance impacting on workplace trust

Uncertainty was a pervasive theme across participants' narratives, considered by senior professionals as defining their work (diagnosis, risk assessment and prescribing):

> *Consultant psychiatrist 2: Psychiatry is all about uncertainty.*

NHS quality governance, not least within mental healthcare, has sought to reduce uncertainty through standardising clinical practice, modifying formats of inter-professional working and supervision, automatic inquiries into fatalities, routinised coordination of care provision, and performance targets and monitoring (amongst various other reforms). Policy-makers and (accordingly) senior-managers have thus attempted to 'control' various practices and scrutinise outcomes, attempting to reduce vulnerability to efficiency pressures and, perhaps above all, to the political and media criticism associated with high profile homicides or suicides committed by mental health service-users (Pilgrim & Ramon 2009).

Squeezed between such policy (and societal) demands for calculability and intractable uncertainty, middle-managers and senior clinicians interpreted services as marked by 'pressure'. Quasi-external governance, emphasising checking rather than trust (imposed by policy-makers via senior managers), accordingly created experiences of vulnerability:

> *Service-manager 1 [1]: I think there's an awful lot of pressure around...particularly…how the services are managed centrally and commissioned. But there is a greater*

requirement...people talk about performance targets and we're becoming very orientated

towards that [...] but that creates a pressure in itself.

The reorientation of work to satisfy quality and performance pressures was referred

to by this manager above as translating into pressure further down the organisation.

This was described as a pervasive and growing feature of work by many

professionals:

Consultant Psychiatrist 2: Increasing pressure all the time. It's not only the reputation
[of the organisation amidst media scrutiny of adverse incidents]*, it's about lots of*

things: it's government targets; it's the organisational targets; it's what they call

'serious untoward incidents'. All of this happens all the time, and it's becoming even

more...

When asked how their role had changed, middle-managers referred to expanding

responsibilities to oversee various features emphasised within new policies, not least

professional performance and quality development:

Service-manager 2: We're expected much more now to manage things like annual

leave and sickness and training. And all those things didn't seem to be at the forefront

maybe ten, fifteen years ago but now...managing your team effectively with the

resources, how we deliver the service, it's very much in the forefront.

Implementing and policing the performance and quality directives designed by

senior counterparts were narrated by middle-managers as shaping their

relationships with professionals. Growing bureaucracy was understood by different

participants as both a cause and effect of deteriorating trust relations and familiarity between professionals and managers:

> *Consultant Psychologist 1: I think there's a bigger distance between senior clinicians and managers than there used to be. So that's changed. Clinicians I think are less involved in big decisions which can be problematic. But...I think that's a question of trust. I think maybe we lost the trust of [senior] managers somewhere along the line, by thinking we knew it all.*

This erosion of trusting relations can partly be understood through the working definition introduced earlier – growing incompatibilities between the interests of senior managers and those of professionals:

> *Community Psychiatric Nurse (CPN) 4:...we can't trust the high up managers...We can't trust them because they have a different agenda and they're not telling us everything, and I know that sounds like a conspiracy theory but they're not…And...well, everybody's about number crunching.*

Middle-managers, with whom professionals were more familiar, were referred to much less frequently as being distrusted. Instead the bureaucratic demands these latter managers implemented were often perceived as a consequence of more senior directorates:

> *Social Worker 1: The managers higher up...they've probably got aims and outcomes that they've got to prove. So in regards to kind of doing paperwork, keeping up contacts and doing any audit things - a lot of that is affected and we probably all find*

that our paperwork is very time consuming and [...] most of us feel quite frustrated

that we can't be doing more things [with service-users]…

Pressures towards 'effectiveness', as imposed by senior managers – themselves described as constrained by scrutinising policy-frameworks – and implemented by middle-managers manifested stress for many professionals working amidst uncertainty. When asked what was challenging about the job, social worker 2 recounted:

Every day, just facing different issues on a day to day basis and that's really quite

stressful...paperwork and keeping up to date with that as well, that's difficult in itself,

making sure everything's on the computer and you've got it all up to date. But it's

just being faced with different scenarios every day, and not knowing whether you've

done the right thing or not by that client.

One important and more common narrative was that regarding the impact of such stress via sickness absences and/or retention problems:

Social worker 2: We get stressed and so staff go off sick, so obviously you need to look

after someone's caseload as well.

Consultant Psychiatrist 2: Well, that's why everybody's understaffed...['juggling'

financial pressures and pressure relating to managing risk].

Interviewer: Really?

Consultant Psychiatrist 2: That's why staff opt out all the time. And even if they don't leave the whole mental health services, they just move from one place to the other because they're just restless, because of the anxiety...I mean I find myself quite fortunate because I'm a person who can deal with that [stress]...but I'm struggling with the fact that the rest of the team I work with are not, and they are always under stress of people leaving and vacancies and so on.

Heterogeneous narratives of 'vulnerability' and resilience were thus apparent. Senior staff's accounts suggested a greater insulation from stress, partly due to a certain 'distance' from specific cases and through greater decision-making discretion and autonomy (Wainwright and Calnan 2002). Amongst lower-level professionals however, sickness absence levels were commonly referred to as a serious issue in two of the three services. This difference was also reflected in the format of narratives (as apparent above), whereas senior professional-managers described stress in a more distanced third-person manner more junior professionals referred to direct experiences in the first-person.

Sickness absence from work stress was referred to as a manifestation of vulnerability, resulting from (instrumental) scrutinising/checking of professionals within management frameworks, which in turn were a response to policy-rooted vulnerabilities noted earlier, alongside the uncertainty of everyday work. Absences were also interpreted as creating difficulties in building effective inter-professional relations and providing quality care:

Manager 1: If someone is sick a lot or off a lot and not contributing to the team in those types of things, and then it starts to feel a little bit uneasy and people start to have splitting and those types of things. They can't trust that the person is gonna be there all the time, meetings get cancelled, or CPA's [care coordination meetings] get cancelled, and that's when the trust starts to unbalance and shift the team around; things like that, commitment to work; that one that comes up here quite a lot.

Sickness absences therefore represented one rather palpable linkage through which the vulnerability of professionals amidst governance and management structures impacted on inter-professional trust, knowledge-sharing opportunities and effectiveness.

Inter-professional relations: shaping productivity and learning

Obstacles to trust were frequently apparent within participant narratives, yet more positive accounts of trust were not uncommon. One manager, of a service which was newer and seemingly better resourced, referred to having high trust in her colleagues – emphasising a need to trust for the sake of efficiency:

Service-manager 3: I have to trust people...that they're doing what they're employed to do...I can't go around looking at everybody's caseloads and making sure that there's a care plan in there, there's a risk assessment in there, that they've printed out their contact records. I have to...you know, delegate…

Relying on trust could, in turn, create efficiencies within the team, due to the lack of 'checking' (see later in this section). Yet even in this team, where the service-manager described trusting competent colleagues, more overarching governance structures

('the whole system') impinged on professional time, shaping interests and practices as reported by the senior professional:

> *Consultant Psychologist 1: It's related to the trustworthiness or untrustworthiness of the whole system, because [my] colleagues' record keeping is often defensive in my view. So they write reams and reams and reams of contact details just in case they...if they're ever called to account.*

Despite the service-managers' aims, accountability pressures imposed via senior management were nevertheless experienced by professionals as rendering them vulnerable, which they described mitigating through bureaucratic-instrumental practice. Vulnerabilities, such as those relating to clinical uncertainty, could also be attended to via more communicative-relational means – such as supervision and support from fellow professionals:

> *Consultant psychologist 1:...that wish to find certainty about diagnosis or prediction and prognosis – to know exactly when someone's going to hurt themselves or someone else – and trying to live with the fact that you can't predict those things with anything like the degree of certainty that we'd want. So we use supervision; especially group supervision is often taken up with that.*

As with spending time with service-users (next section), more communicative-relational approaches such as supervision (formal and informal) were a common way in which professionals and managers referred to dealing with vulnerability amidst uncertainty. For more junior professionals within the team this was a vital

means of learning and being supported. Supervision was understood as combining communicative activity (sharing experiences and understandings) with instrumental development (teaching and facilitating better or safer outcomes).

Assistant psychologist: I think there's times when I've thought: 'oh, I've really not handled something very well'...I've kind of gone in the next day and gone: 'that was just awful' and...So I think that's quite often that...people offload a bit...Yeah, I think that's quite helpful and yes, that is a trusting thing isn't it – to be able to do that.

Similarly, for senior professionals and managers, supervision was described as a way of providing (communicative) support as well as ensuring key (instrumental) functions were fulfilled. As is apparent from both these excerpts (above and below), reciprocal trust was referred to as vital to effective supervision:

Consultant psychiatrist 3: The trust relationship is very important...you rely on them and you see difficult cases with them and support them in difficult cases – and they support you. And we are, with the 'new ways of working', for the psychiatrists we have to have...more of an advisory role.

Here the psychiatrist's development of trusting relationship is interpreted within the limits imposed by the policy framework (Department of Health 2005) in which he worked. This reduced the 'hands-on' role with service-users and therefore could

render interactions with and trust in colleagues more necessary, as a way of coping with this more advisory function. More senior participants thus also referred to 'relying' upon or being supported by their junior colleagues amidst trust relations, as well as being depended upon themselves. Trust relations, within governance frameworks which rendered senior practitioners vulnerable, were therefore not as neatly 'vertical' as one might assume.

Yet as beneficial as interactive learning and support could be, excessive supervision sessions and other meetings were also referred to as potentially eroding time with service-users:

Social Worker 3: There's lots of supervision - you've already picked up on that?!...

I'd say client time is probably only a third but the reason for that is because of travel, meetings and paperwork.

Supervision and group meetings were interpreted as sometimes being more concerned with checking on professionals work (surveillance) than with constructive learning and support. In some cases these experiences of checking were related to the broader bureaucratising tendencies of the NHS. Instrumental-strategic action could in this way function 'parasitically' through ostensibly communicative processes (Habermas 1987:187; Weiss 1979). Distinctions between trust and checking (Davies and Mannion 2000; Adler 2001) are important here in distinguishing between aspects of supervision which, facilitated by trust, were described as enabling the sharing of useful knowledge and mutual learning and those which

were held to serve the function of verification and audit while consuming time.

Time has been found to play a vital role in trust relations (Dibben & Lean 2003). It emerged within the interview narratives as one further fundamental element which – as both an antecedent and product of trust – was described as relevant in inter-linkages between trust relations. Too many formal meetings and too much paperwork was seen as reducing the availability and flexibility of professionals. This was interpreted as impacting profoundly upon relations with service-users (see next section) but was also described as influencing relations amongst colleagues. In one service which had comparatively few meetings, this more junior professional inferred the accessibility and consequent support of his colleagues:

> *Social Worker 2: Because, you know, I think any problem, any issues - there's always someone around that you can speak to and they will take that time out to kind of give you advice and, you know, kind of tell you whether you're doing the right thing by that, or give you advice on how maybe to approach situations.*

However the availability of this support and supervision, and the trust which was seen earlier as underpinning this, was described by the same professional as being under threat:

> *Social Worker 2: You know...[trust] depends on various factors, how much pressure you are under, how much time you have got…I mean in terms of...relationship with...clients, to colleagues, you know, to the management, everything!...Now we're getting more pressure so obviously, you know, lack of staff and more cases...*

Resource issues, sickness absences, related pressures to take on larger case-loads, alongside governance pressures (see earlier) were referred to as combining to consume time. In contrast, within the service where the manager referred to a particular keenness to trust (see the start of this section), professionals understood trusting relations within the team and management as enhancing productivity and commitment:

> *Assistant psychologist:…people give more hours than they should really...people feel almost that because we're trusted it...it's almost reciprocal then, you know – "well, I won't put that half an hour down", you know, "that's fine". So actually I think it's probably a lot, lot more productive...and you don't have people spending two hours moaning about the management [as experienced in a previous workplace] because there's not anything to moan about. So, yeah, I think that works really, really well and hopefully it will stay like that.*

Professional and service-user relations: the importance and hindrance of interaction-time, competence and care

The preceding quotation shows how professionals' interests and practices could be potently shaped by workplace trust relations involving middle-management (Gilson et al. 2005). Conversely, earlier in the preceding section productivity and quality decision-making were interpreted as being impeded when supervision became partially colonised as surveillance or where bureaucratic monitoring was seen as consuming professional time. Professionals' various relations to governance frameworks, management and colleagues – as understood through open trusting

communication, and/or defensiveness and experiences of 'pressure' – were interpreted as impacting significantly on professional practice, within service-users' narratives:

> *Service-user 3: I was introduced to the concept of 'key worker' and the first one was absolutely crap and was off [sick] more than he was there.*

Sickness absence, as described earlier, was a serious problem within a number of participants' accounts, described as contributing directly and indirectly to particular professionals' relational distance from service-users.

Users' narratives in particular included many experiences of limited trust, although most users described at least one professional whom they had trusted. Trust was referred to, explicitly and implicitly, as developing in various ways but most consistently involved interpretations of instrumental competence and communicative relation-building:

> *Service-user 7: I had a doctor 10 years ago and I think he spent a lot of time to get to know me and he diagnosed me as having something else and [...] It really seemed to hit the nail on the head and what I was feeling and what my thoughts were at the time.*

Development of relations over time was thus salient for mutual understanding and

awareness of interests (needs). Growing familiarity, rapport and trust were recurrently reported by professionals and service-users alike as integral to effective care relationships:

> *Service-user 8: It just seemed like she kind of had some care and concern, which I'm not saying the other guy didn't, but it just seemed like time was slower there...*
>
> *You have to trust them enough to tell them...you know, it's stuff that you feel ashamed about really...*
>
> *But it really felt like she just kind of put me right up the list for that period of time and that it really didn't matter what else was going on.*

Sensitive information, disclosed within trusting relations, further enabled appropriate assistance and, correspondingly, quality outcomes. Similar processes were also pertinent for professionals, in feeling able to discuss difficult cases with colleagues and supervisors, but trust and time were especially vital for service-users in overcoming stigma and shame (vulnerability) to disclose difficulties. *Time* here was as much a subjective basis of experience and meaning-making (Schutz 1972) as an objective resource; a slower 'cadence' of interaction assisting open communication and quality care.

Such positive experiences would likely have been impeded by sickness absences or the regular rotation of professionals working with particular users due to retention problems (Cook et al. 2004). Professionals similarly underlined the importance of time for relation building, as well as its erosion through various processes:

Social Worker 2: I think...rapport then depends on the caseload [...] When I started working with the clients...initially and I may have a good rapport and then...I have currently got something approximating 28/30 cases so I would say the last clients on my list may not be... may not have that [rapport] *because I don't have enough time to spend with them. So obviously...external factors affect it anyway and the trust [...] And that's changed a lot...*

Interviewer: Why is that?

Social Worker 2: Because of the pressure of paperwork; because of the pressure of the nature of the work now.

This significance of time and familiarity thus underscores the value of trusting manager-professional and inter-professional relations in 'freeing up' time to devote to users. Similarly, high levels of commitment, described by the professional quoted at the end of the preceding section as being galvanised by managerial trust, could be seen as underpinning quality care and users' inferences of trust:

Service-user 3: She is trained to do the job properly and she understands what the job involves and she knows that at times that she will have to make a commitment which is, you know, outlined in her contract of employment but sometimes a commitment that goes beyond that in order to make sure that clients are safe and that the paperwork's done.

But I didn't say anything about how that impacts on me and what that has meant to me over the time that she's been my key worker [...] because it's one thing for her to be all these things but if it doesn't have any value or impact for me then it's...it's not that

important. I would say that out of all the people I come into contact [with] bar none –

including individuals that are not employed by the NHS – I would trust her the most.

These last few lines emphasised the subjective, interpretative experiences of care and trust. However such interpretations of training and commitment were also connected to practices of quality training and informal norms of professional duty.

As described earlier, knowledge intensive organisations such as mental health services rely on trust amongst staff to enable sufficient information sharing in order to drive quality care. The effective application of this knowledge was also understood as bearing upon care outcomes and consequently on users' trust (Das and Teng 2001). Management and accountability frameworks were in various ways described by professionals as inhibiting optimal care decisions, in spite of knowledge to the contrary:

> *Psychiatrist 2: Another thing that I think is very difficult is...how much the politics*
> *and the dynamics of the organisation interfere with clinical decisions...that I have to*
> *practice defensively at some point [...] So I'm of the opinion that due to this*
> *sometimes, in psychiatry in particular, sometimes we do not help patients to improve*
> *and on the contrary...we're creating users of the service because some of the things*
> *that we do is [sic] reinforcing certain behaviour and a certain pattern of*
> *thinking...What we need to do maybe is to work on it to try and...well minimise it but*
> *instead...because we have to act on the risk and we have to protect ourselves and*
> *protect the service, we reinforce it.*

Such risk-governance approaches have been argued to lead to the service-user being approached as a risk 'object' rather than a whole human being (Castel 1991), indicating a further indirect and negative influence of policy-frameworks, via management and supervisory relations, upon professional-user relations. More directly, the highly publicised risk-focused logics of recent policies within English mental health services (Pilgrim & Roman 2009), alongside negative individual experiences at access points (especially of in-patient experiences), coalesced towards one general impression of institutional interests diverging from those of users:

> *Service-user 7: Well they're not interested in you. They're just... They're just there for the daily routine, you know, to make sure that you do all of the things you're supposed to do; and to them you're just a schizophrenic…*

Discussion – from 'trust chains' to vicious and virtuous 'cycles'

Central to the analysis above is the identification of: a.) a number of processes which are useful in understanding how trusting or distrusting relationships across healthcare organisations may be impacted by, and in turn impact upon, other relationships; b.) various ways in which processes shaping knowledge-sharing and quality care provision are interwoven within these chains of (dis)trust. The high levels of uncertainty, vulnerability and fragile trust dynamics which existed in the psychosis service settings were useful in making key mechanisms and interdependencies visible which may have remained more hidden or taken-for-granted in 'high-trust' environments (Bijlsma-Frankema and Klein Woolthuis 2005).

This analysis and theorisation is aimed at advancing medical sociological and health policy understandings, partly through insights from organisational studies (Currie et al. 2012).

'Trust chains', in proliferating certain relational-communicative and instrumental-strategic tendencies across organisations, assist in explaining the emergence of broader organisational patterns of (dis)trust and (poor) quality care. Vicious or virtuous 'cycles' of trust help capture important cultural underpinnings of knowledge-sharing, learning, and performance (Gilson et al. 2006). Meso-level analysis of trust chains was built through micro-linkages or 'lynchpins', understood through vulnerability, interests, uncertainty and time being both antecedents and products of trust. These four lynchpins may be usefully divided between those – vulnerability and interests – which are of most interest to studies of trust, power and control within organisations, and those – uncertainty/knowledge and time – which are most directly relevant to quality and effectiveness. The central mechanisms and many of the concepts within our analytical framework are, through their abstract qualities, likely to be pertinent for many healthcare-organisational contexts. However our findings are in various ways particular to our case study and further/alternative lynch-pins may well be identified across other organisational contexts.

The experiences of individual actors within certain (dis)trusting relations correspondingly enabled or hindered these actors' familiarity and openness with other actors. In our case study, pressures enacted by policy makers and imposed via

managers were regularly seen to lead to vulnerability (accountability pressures, strenuous workload, work-stress), resulting in instrumental-strategic behaviours (absence from work, defensive paperwork, defensive clinical practice, reduced interactions with colleagues). Such responses to vulnerability created new forms of uncertainty and vulnerability amongst managers and professionals (see figure 2 – where each arrow represents potential sources of vulnerability[2]); for example through limited communicative time or poor health, which in turn eroded or colonised knowledge sharing (in the short-term), familiarity and relationship formation (in the longer-term). It followed that new uncertainties and vulnerabilities then tended to emerge for a range of related actors – managers, professionals and/or users – impacting directly and indirectly on relationships, communication and quality care provision. Again, while uncertainties and vulnerabilities are intrinsic to contexts where trust becomes necessary, these will manifest themselves in many different ways and figure 2 is by no means comprehensive or exhaustive, even of this one small case study.

Figure 2 here

Processes around such lynchpins also assist in understanding why negative, vicious circles are far from inevitable. Above we have explored how actors may respond to uncertainty and vulnerability in different ways. The nature of these responses – whether towards more instrumental/strategic formats of behaviour in seeking to defend oneself *against* uncertainty, or more openly communicative action in seeking to *resolve* uncertainty through knowledge sharing, mutual understanding and

familiarity – are significant in understanding the generation of vicious circles or, alternatively, virtuous circles of trust. Enduring norms for responding to vulnerability constitute one important basis for understanding the orientation of behaviour (towards more communicative-relational or defensive-bureaucratic), as shaped by organisational, professional and/or socio-biographical contexts. Whether actors felt trusted or not was one key organisational factor.

The more linear ordering of the Findings sub-sections above implies a 'top down' chain of trust or, as has often been the case in the data presented here, distrust; one where certain overarching governance frameworks more or less directly shaped working environments and relations which were described as dysfunctional for trust. Importantly, many of these negative pressures resulted from the implementation of quality and performance frameworks.

Yet as was emphasised at the very start of the analysis section, certain 'bottom up' tendencies also existed due to the particularly high levels of uncertainty which were described as inherent to the experience of psychosis – both for those with a diagnosis and for those with the responsibility of caring for this vulnerable group of service-users. It is the seeming incompatibility between this intractable and heightened uncertainty and the stringent demands for high levels of accountability and monitoring which create such relational tensions for the managers, professionals and users who must interact in the midst of these chains. Chains of (dis)trust may thus stretch right through and beyond an organisation, with the nature of users/patients at one end of the chain, and the policy or legal frameworks at the other, exerting

important influences on the relational dynamics in-between.

The conceptual relationships identified here (summarised in figures 1 and 2) build on existing understandings (Gilson et al. 2005) by identifying certain key mechanisms which are fundamental to connections between different trust relations. The conceptual tool of 'trust chains' should not only be applied in a 'link by link' approach however. Some more complex inter-linking across chains is captured in figure 2. For example, we have described that although senior managers had little interactive/relational contact with professionals, their policies and the interests inferred from these nonetheless had important impacts on professional work and sense-making towards middle-management. Senior managers were sometimes typified via policies as 'the organisation', more or less negatively. Policy and management directives could also impact on service-users' trust relations with professionals, with the latter actors' typified as being embedded within particular overarching management norms (Möllering 2005). Dynamics of trust chains accordingly function not only through proximal linkages, but also via a more distant association/contamination and the resulting impact within actors' interpretative schemes (Schutz 1972).

Phenomenologically-grounded conceptualisations of trust chains may thus be unusually powerful at illuminating – though by no means fully capturing – important cultural tendencies which are highly salient to quality and safety practices, if we understand 'organisational culture' as 'patterns of relationships and meaning' (Ormrod 2003: 230). The analytical framework presented here requires

further exploration and scrutiny across a range of contexts beyond English mental healthcare – including higher-trust organisational and different clinical settings – for further refinement and development. 'Quality' in caring for people with chronic and severe mental health problems, as described by participants in our study, is arguably more relational than many other healthcare settings while ambiguity around what quality means is unusually heightened, as are organisational sensitivities towards risk. Nevertheless, all healthcare services rely on successfully refining communicative and instrumental processes, with chains of (dis)trust potentially potent shapers of cultures of knowledge-sharing, learning and care-giving.

Notes

[1] An ellipsis is used to indicate a pause or hesitation or in place of recurring expressions such as 'urm', 'kinda', 'like', 'you know' which added little content-wise and could potentially make the participant more easily identifiable. On a few occasions where participants repeated or restarted a sentence the repetition is omitted and marked with [...]. Where one excerpt includes two pieces of transcript which were originally uttered within two distinct sentences this is indicated by a starting a new line.

[2] Various terms are borrowed from Gillespie and Dietz (2009). Following Gilson and colleagues (2005), all processes depicted in fig.2 are embedded within a broader social context.

References

Acemoglu, D. and Wolitzky, A. (2012) Cycles of distrust: an economic model. NBER Working Paper No. 18257. Available at: http://economics.mit.edu/files/7914 (accessed 1 December 2013).

Adler, P. (2001) Market, Hierarchy, and Trust: The Knowledge Economy and the Future of Capitalism, *Organization Science,*12,2,215-234.

Alaszewski, A. (2005) Risk, safety and organisational change in healthcare?, *Health, Risk and Society,*7,4,315-318.

Appleby, L. (2008) Services for ethnic minorities: a question of trust. *Psychiatric Bulletin,*32,11,401-2.

Bevan, G. and Hood, C. (2006) What's measured is what matters: targets and gaming in the English public health care system. *Public Administration,*84,3,517-38.

Bijlsma-Frankema, K. and Klein-Woolthuis, R. (2005) *Trust under pressure: empirical investigations of trust and trust building in uncertain circumstances*. Cheltenham: Edward Elgar.

Brown, P. (2008) Trusting in the New NHS: instrumental versus communicative action. *Sociology of Health and Illness*, 30,3,349-363.

Brown, P. (2011) The concept of lifeworld as a tool in analysing health-care work: exploring professionals' resistance to governance through subjectivity, norms and experiential knowledge. *Social Theory and Health*, 9,2,147-165.

Brown, P. and Calnan, M. (2013) Trust as a means of bridging the management of risk and the meeting of need: a case study in mental health service provision. *Social Policy & Administration,*47,3,242-261.

Brownlie, J. (2008) Conceptualising trust and health. In Brownlie, J. Greene, A. and

Howson, A. (eds) *Researching Trust and Health.*, London: Routledge,pp.17-32.

Burns, T. Priebe, S. (1999) Mental healthcare failure in England: myth and reality.

British Journal of Psychiatry 174:191-2.

Calnan, M. and Rowe, R. (2008) *Trust Matters in Healthcare*, Buckingham: Open

University Press.

Castel, R. (1991) From Dangerousness to Risk. In Burchell, G., Gordon, C. and Miller,

P. (eds) *The Foucault Effect – Studies in Governmentality*. Hemel Hempstead: Harvester

Wheatsheaf, pp. 281-298.

Cook, K., Kramer, R., Thom, D., Stepanikova, I., Bailey-Molborn,S. and Cooper, R.

(2004) Trust and Distrust in Patient-Physician Relationships: Perceived Determinants

of High- and Low-Trust Relationships in Managed-Care Settings. In Kramer and

Cook (eds.) *Trust and distrust in organizations: Dilemmas and approaches*. New York:

Russell Sage Foundation, pp.65-98.

Currie, G., Dingwall, R., Kitchener, M. and Waring, J. (2012) Let's dance: Organization

studies, medical sociology and health policy. *Social Science and Medicine*,74,3,273-280.

Das, T. & Bing-Sheng, T. (2001) Trust, Control and Risk in Strategic Alliances: an

integrative framework. *Organization Studies*,22,2,251-283.

Davies, H. and Mannion, R. (2000) Clinical governance: striking a balance between

checking and trusting. In Smith, P. (ed) *Reforming Markets in Health Care: an economic

perspective*. Buckingham: Open University Press,pp.246-67.

Department of Health (1997) The New NHS: Modern, Dependable. London: DoH.

Department of Health (2000) *An Organisation with a Memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer*. London: TSO.

Department of Health (2005) *New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multiagency contexts*. London: DoH.

Department of Health (2008) *Refocusing the care programme approach: Policy and positive practice guidance*. London: DoH

Dibben, M. and Lean, M. (2003) Achieving compliance in chronic illness management: illustrations of trust relationships between physicians and nutrition clinic patients. *Health, Risk and Society,* 5,3,241–248.

Dirks, K. and Ferrin, D. (2001) The role of trust in organizational settings. *Organization Science,* 12,4,450-467.

Dixon-Woods, M., Baker, R., Charles, K. et al. (2014) Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *BMJ:Quality & Safety,*23,106-115.

Eisenhardt, K. (1989) Building theories from case study research. *The Academy of Managment Review* 14,4,532-550.

Giddens, A. (1990) *The Consequences of Modernity*. Cambridge: Polity

Gillespie, N. and Dietz, G. (2009) Trust repair after an organization-level failure. *Academy of Management Review*,34,127-145.

Gilson, L., Palmer, N. and Schneider, H. (2005) Trust and health worker performance: exploring a conceptual framework using South African Evidence. *Social Science and Medicine*,61,1418-1429.

Habermas, J. (1987) *Theory of Communicative Action. Volume Two: Lifeworld and System: a critique of functionalist reason*. Cambridge: Polity.

Langan, J. (2010) Challenging assumptions about risk factors and the role of screening for violence risk in the field of mental health. *Health, Risk and Society*,12,2,85-100.

Luhmann, N. (1979) *Trust and Power*. Chichester: Wiley.

Mechanic, D. and Meyer, S. (2000) Concepts of trust among patients with serious illness. *Social Science and Medicine*,51,5,657-668.

Möllering, G. (2005) The Trust/Control Duality: An Integrative Perspective on Positive Expectations of Others. *International Sociology*,20,3,283-305.

Möllering, G. (2006) *Trust: Reason, routine, reflexivity*. Oxford: Elsevier.

Neuman, W. (1997) *Social Research Methods: Qualitative and Quantitative Approaches*. Boston: Allyn and Bacon.

Ormord, S. (2003) Organisational culture in health service policy and research: 'third-way' political fad or policy development? *Policy and Politics*,31,2,227-237.

Ostrom, E. (2005) Toward a behavioural theory linking trust, reciprocity and reputation. In Ostrom, E. and Walker, J. (eds) *Trust and Reciprocity: Interdisciplinary Lessons for Experimental Research*. New York: Russell Sage, pp.19-79.

Pilgrim, D. and Shulamit, R. (2009) English mental health policy under New Labour. *Policy and Politics*,37,2,273-88.

Pilgrim, D., Tomasini, F. and Vassilev, I. (2011) *Examining Trust in Health care*. Basingstoke: Palgrave Macmillan.

Schutz, A. (1972) *The Phenomenology of the Social World*. London: Heinemann.

Sheaff, R. and Pilgrim, D. (2006) Can learning organizations survive in the newer NHS. *Implementation Science*,1,1-27.

Smith, L. (2008) How ethical is ethical research? Recruiting marginalized, vulnerable groups into health services research. *Journal of Advanced Nursing*,62,2,248-57.

Smith, J. and Osborn, M. (2003) Interpretative phenomenological analysis. In Breakwell G. (ed) *Doing Social Psychology Research*. Oxford: Blackwell,pp.53-80.

Tan, H.H and Lim, A. (2009) Trust in co-workers and trust in organizations. *Journal of Psychology*,143,1,45-66.

Wainwright, D. and Calnan, M. (2002) *Work stress: the making of a modern epidemic*. Buckingham: Open University Press.

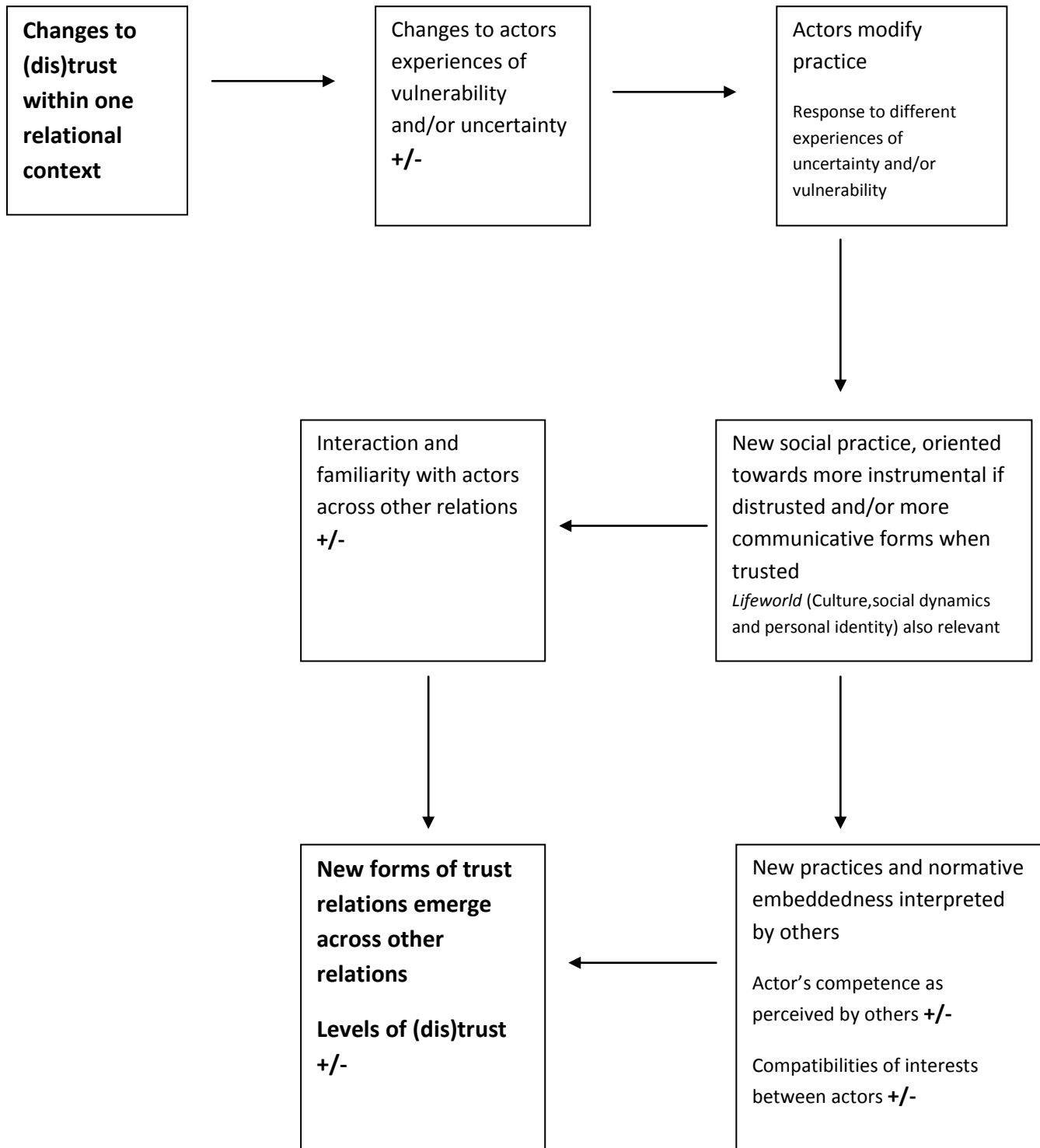Walshe, K. (2003) Understanding and learning from organisational failure. *Quality and Safety in Healthcare*,12,81-2.

Waring, J. (2005) Beyond blame: the cultural barriers to medical incident reporting", *Social Science and Medicine*,60,1927-1935.

Waring, J. (2007) Adaptive regulation or governmentality: patient safety and the changing regulation of medicine, *Sociology of Health and Illness* 29,2,163-79.

Waring, J. and Bishop, S. (2010) Watercooler learning: knowledge sharing at the clinical backstage and its contribution to patient safety, *Journal of Health, Organisation and Management*, 24,4,325-342.

Warner, J. (2006) Inquiry reports as active texts and their function in relation to professional practice in mental health. *Health, Risk and Society*,8,3,223-237.

Weiss, C. (1979) The many meanings of research utilization. *Public Administration Review* 39,5,426-431.

Zimmerman, D. (1971) Record keeping and the intake process in a public welfare organization. In S. Wheeler (ed.) *On Record: files and dossiers in American Life*. New York: Russell Sage,pp.319-54.

Table 1. Participant characteristics

Type of Service	Service-users	Professionals	Service-managers
Early Intervention	2	4 (consultant, assistant psychologist, social worker, community psychiatric nurse - CPN)	1
Assertive Outreach	1	3 (consultant, social worker, CPN).	1
Standard Community	5	3 (consultant, social worker, CPN).	1

Figure 1 – Micro-dynamics of changing trust processes across different relations

| **Changes to (dis)trust within one relational context** | → | Changes to actors experiences of vulnerability and/or uncertainty **+/-** | → | Actors modify practice

Response to different experiences of uncertainty and/or vulnerability |

| Interaction and familiarity with actors across other relations **+/-** | ← | New social practice, oriented towards more instrumental if distrusted and/or more communicative forms when trusted
Lifeworld (Culture,social dynamics and personal identity) also relevant |

| **New forms of trust relations emerge across other relations**

Levels of (dis)trust +/- | ← | New practices and normative embeddedness interpreted by others

Actor's competence as perceived by others **+/-**

Compatibilities of interests between actors **+/-** |

Figure 2 – Salient chains of interwoven relations and components across and beyond mental healthcare organisations