

# Madness and Organization: Informed Management and Empowerment

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## Abstract

Empowerment has become a popular and alluring concept associated with ideas of emancipation, participation, and the delegation of decision making. It is seen as a way of enabling individuals, organizations, or even nations to exert a greater degree of control over their destinies. In addition, information technology (IT) is seen as an enabling medium through which empowerment can be realized. Yet, in some cases technology is also viewed as the source of oppression and control, while empowerment is regarded as a myth. This paper addresses the relationship between IT and empowerment in the context of recent developments within the management and delivery of care in mental health services. Drawing upon research in an NHS psychiatry department, it examines the process by which individuals (both mental health service professionals and patients) are constituted as empowered through specific discursive practices centered on information and information management.

## 1. INTRODUCTION

As we come to the end of the current millennium, it is clear that many see developments in information technology (IT) as an indicator of modernization, or even post modernity (Poster 1990). Visions of the modernized organization revolving around notions of managers empowered by information, flattened hierarchies, network organizational designs, not to mention the “virtual” organization, all presuppose an IT infrastructure both to help bring about, and then to sustain, such changes. But further, beyond the advertising copy and the case studies of how IT *changed the world*, there is also a sense in which, for some at least, IT provides the focus for a more basic expression of hope for the future. In particular, the Internet global communications network has

become a repository for a wide variety of goals and imaginings: while the view of the computer as Big Brother still lurks in the background, in certain quarters the image of the empowered citizen brandishing a “PC plus a modem” has come to represent an icon of egalitarianism and democratic participation.<sup>1</sup>

For individuals, organizations (Peters 1989; Zuboff 1989), and sovereign states (Porter 1990; Toffler 1980), the future is seen to be characterized by empowerment through IT.<sup>2</sup> In part because of the belief that everything can be conceived in information-theoretic terms, IT is regarded as a technology that will reach into every interstice of social life while at the same time transforming social, educational, professional, and other working practices beyond recognition. In particular, to the extent that IT provides the lure of increased organizational control, visibility, efficiency and flexibility, organizations and management are increasingly constituted around information processing and information management. In this regard the UK National Health Service (NHS) is no exception. Rising demand for health care and constraints on financial resources, coupled with the notion that, historically speaking, the NHS has been under-managed, have provided a potent concoction for which IT is seen as the antidote. The hope being that IT would enable the connection between service activity and its costs to become visible and thus assist the search for greater efficiency.

In this paper we reflect upon some recent developments in the management and delivery of care in mental health services where one finds that notions of empowerment through IT — for managers, practitioners, and patients — circulate alongside (muted) fears of increasing central control, cutbacks and a commercially-minded search for efficiency. The concept of empowerment raises many difficult issues.<sup>3</sup> For though the equation of computers with power is almost taken for granted, what remains in dispute is whether the exercise of that power is ultimately enslaving or emancipating. We specifically avoid trying to solve the empowerment conundrum *per se*, or indeed evaluate particular instances of empowerment, for to do so would require some Archimedean position or neutral standpoint against which it could be judged. Rather, we aim to consider how subjects are *constituted* as empowered, in particular through the institution of IT mediated practices which open up a space for thought and action centered on information and information management (Bloomfield and Coombs 1992).

Our starting point is a brief discussion of some recurrent themes in studies of the social *impact* of technology, in contrast to which we develop an alternative line of enquiry focussed on the relationship between thought, information, information management and users of information systems. We will then consider the case of mental health services and go on to present a case study of the development of information management practices in a mental health department of

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<sup>1</sup>Although many would challenge the individualist and free market values often embodied in the political agenda among some Internet groups, not to mention its effective exclusion of women.

<sup>2</sup>To a degree, this hope is paralleled by a fear that those who let the opportunities afforded by IT pass them by will be reduced to, or remain, an underclass: for example, as the notion of computer literacy threatens to erect a new barrier of access to employment and even citizenship.

<sup>3</sup>For two different approaches, see Clement (1994) and Eccles (1993). For a critical discussion of empowerment within the context of corporate culturalism, see Willmott (1993).

an NHS Trust hospital. In particular, we are interested in the changing conceptualization of patients, mental health workers, and managers, which are mediated and reinforced by recent moves to improve the management of health care delivery and to empower patients and health professionals.

## 2. TECHNOLOGY: BEYOND GOOD AND EVIL

Discussions of the social *impact* of IT frequently revolve around a set of now familiar questions: does IT deskill or enskill, enslave or empower, is it an instrument of managerial (class) control or does it represent the potential for worker autonomy (Bloomfield and Vurdubakis 1992)? The fears about control stem from the surveillance potential associated with IT, and in this connection the (dis)empowering effects have been explored through the Foucauldian metaphor of the panopticon — in this case the *electronic panopticon* (Webster and Robbins 1989; Sewell and Wilkinson 1992). In contrast, for Zuboff (1989) the electronic panopticon represents a manifestation of an outdated modality of managerial control, one which should be superseded by networked organizations populated by knowledge workers empowered through their access to, and use of, IT. For Zuboff, then, IT is seen to have the capacity both to empower and disempower, this depending on the way that it is applied within the organization.

Rather like any other technology, IT serves as a object to which all manner of familiar views and their underlying problem become assigned. In Turkle's analogy, computers are rather like the ink blots of the Rorschach Test: all manner of virtues and vices can be read off them (Turkle 1984: 5). However, although IT cannot be thought of as either good or bad in *itself*, neither can it be considered to be politically neutral. Every technology is developed for a particular context, with specific users in mind, and is envisaged as a contribution to specific purposes or goals (of course, these may well be subverted as a result of the unintended consequences of an innovation). In studying technology, we need to be sensitive to the exercise of power as well as issues of distribution (Law 1991) but we must do so without *reducing* technological developments to either managerial or technical imperatives.

Thus, rather than considering the *impact* of IT on mental health services, we wish to consider the changes in the relationships between, for example, mental health workers and patients, or practitioners and managers, which are presupposed and modified by current initiatives centered on IT. In the terminology of Akrich (1992), we seek a “de-description” of technology: that is, we aim to unravel the “script” of technological practice which users are called upon to play and which is “inscribed” in technology. Hence the term “de-description” or “de-inscription” — that is, to reverse the process of inscription and thus reveal or deconstruct the user script. In our case, we endeavor to illuminate the scripts presumed for users (be they managers, other health professionals, or patients) and inscribed in the subsequent information systems.<sup>4</sup> Similarly, we aim to elucidate the moral order represented in the user scripts for technological practice. In terms of IT, this order constitutes the information-related activities of users, making sense of their practice and justifying its dissemination as a new hallmark of professional responsibility and

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<sup>4</sup>By which we mean the whole heterogeneous network of machines (hardware/software, etc.), human beings, and discursive practices of data gathering, etc.

accountability. This necessitates that we discuss the changing view of mental health expertise, the enhanced role of information in service management, and the subjectivity of the mental health patient.

### **3. RECONCEPTUALIZING THE WORLD THROUGH IT**

In contrast to studies of IT and the labor process, or the political shaping of technology more generally (Winner 1980; MacKenzie and Wajcman 1985), rather less attention has been paid to the cognitive aspects of IT: for instance, to the ways in which thinking about the world in terms of information and information processing changes our conceptualization of ourselves and the world around us. Examples in this vein (though admittedly from a variety of different theoretical and political perspectives) include Weizenbaum's (1976) argument about instrumental reason in the realm of computing, and Artificial Intelligence research in particular; Turkle's (1984) socio-psychologically oriented study of children's and hackers' affinities with personal computers; and Heim's (1987) philosophical discussion of writing in the context of the development of word processing. The latter is of particular interest here because of the centrality of discursive practices within the information management procedures which are increasingly part-and-parcel of the delivery of mental health care. Heim's argument draws upon Walter Ong's transformative hypothesis which (very simply, and crudely) sees an intimate connection between the human psyche and the prevailing technologies of representation and communication. Among other things, the change from oral to print-based cultures marked a shift in human consciousness: from an acoustic to a visual means of information transmission, from an aural to a visual sensitivity toward reality. While we are not pursuing an argument of such broad scale and historical sweep here, it is nonetheless interesting to speculate about the possible analogous changes within mental health services. More specifically, what can be made of those changes in the assessment and management of patient needs which increasingly center on the processing of forms and lists; where talking and listening to the patient is mediated by the need to complete a form — for administrative purposes of information management, to identify patient's needs, and to plan their future care? Lists and forms may appear as mundane features of administrative/managerial practice but they are a key to much broader issues than such a designation allows. "Large-scale decision making is impossible without lists. These in turn entrain whole series of substantive political and cognitive changes in the classes they inventory" (Bowker and Star 1991, pp. 74).

While we do not have the space here to attempt a substantive answer to the question outlined above, it does serve a useful purpose in signaling the distance between conventional treatments of computers and power and the sort of research questions we seek to pursue.

Studies have also been done on the work of specific professional groups. For instance, Mathiassen and Andersen (1983) have attempted to explore the changing semiotics of communication in nursing practice resulting from a move from paper-based to computer-based patient records on wards. Put simply, they argue that the change from a situation in which information was formulated by nurses and hand-written on cards (this being backed-up orally during shift change-overs), to one in which nurses recorded patient details by making selections from predetermined menus on a computer screen, represents a shift from cognition centered on interpretation to one revolving around classification. Similarly, Wagner (1993) has sought to

explore the role of computers in the cultural transformation of nursing, with particular reference to questions of gender.

Here we are interested in the changing conceptions of the expert-patient relationship, the subjectivity of mental health professionals (including psychiatrists and psychiatric nurses) and of patients, and the specific role now allocated to information and information technology in mental health services. In short, we seek to elaborate the mutual interdependence between the conceptualization of the "empowered" subjects of modern psychiatric practice — be they managers, psychiatric professionals, or patients — and the role given to information and information systems in enabling that empowerment.

#### **4. THE SUBJECT IN PSYCHIATRY: INFORMATION AND EMPOWERMENT**

The history of psychiatry is a large and contentious topic which has been periodically marked by a series of radical critiques regarding orthodox knowledge and practice. The late nineteenth century and early twentieth century was seen to be a period of revolution with major advances in clinical treatment, the development of new approaches by psychiatric and psychological experts, new technology in the form of drugs, the legal status of the mentally ill, and state-run programs of welfare policies. Further, in the last fifty to sixty years there has been a dramatic shift in the conceptualization of the psychiatric patient. As Armstrong notes, for some considerable time "the patient was viewed essentially as a passive object in which was contained interesting pathology." (Armstrong 1982, pp. 119) However, increasingly (in many Western societies), the view of the patient-as-object has now given way to a more holistic perspective: the patient is a *person* rather than an object with a diseased mind. They have rights and with appropriate assistance may (re)gain their autonomy as self-directing individuals. The majority of approaches developed within this period seem to have encouraged a process of self-reflection and analysis including client-centered therapy (Rogers 1951), Gestalt Therapy (Perls, Hefferline and Goodman 1951), Transactional Analysis (Harris 1969), Primal Therapy (Janov 1970), and Bioenergetics (Lowen 1975), while a more radical political program was envisaged by the anti-psychiatry movement of the 1960s (Cooper 1974; Laing 1960 1967). (For more recent reviews of psychiatry, see Miller and Rose 1986; Sedgwick 1982; Szasz 1992).

The issue of self-advocacy and user rights should not, however, be seen as a recent development. For instance, groups such as the John Percival Alleged Lunatics Friendly Society date back to the nineteenth century (Conlan 1992). It was not until the 1960s and 1970s that the civil rights movement took hold, with various campaigns against psychiatric oppression, while during the 1980s several local pressure groups were formed and later developed into national organizations (Conlan 1992). More recently these groups have received an increased level of recognition and funding which has enabled them to participate to a greater extent in training, research, and planning initiatives that serve to promote the issues surrounding self-advocacy and user empowerment.

In the UK, the aim of patient empowerment received its greatest expression with the launch of the care in the community program (Department of Health and Social Security 1989). No longer is the patient to be captured within the structure of the hospital environment — the total

institution according to Goffman (1968) — which governs the patient's eating habits, the administration of drugs, close supervision and a network of support. Although not completely abandoned, the in-patient scenario has been largely replaced by the community setting which is seen by some as a more suitable environment for patient rehabilitation and care.

The concept of empowering patients has taken specific form in moves to increase their participation in the derivation of care plans — that is, agreed programs of care — and the assessment of their needs. These have come about not only because of pressure on the part of various user and advocacy groups, but have also been promoted by Department of Health directives and guidelines associated with community care. The Department's moves in this direction present an interesting and complex topic that would take us beyond the scope of the argument here. However, it is useful to note that, in addition to the increased recognition of the rights and sovereignty of the mental health patient, there has also been a powerful impetus to reduce the burgeoning costs of service provision. The costs of maintaining hospital beds (of which nursing represents the greatest factor) — the so-called “hotel costs” — tie up a significant proportion of NHS resources, so any reorganization which envisaged a move away from such provision would have seemed welcome.

The documents associated with *care in the community* tend to highlight the need for patient participation in a “needs-led” approach to care.

For the last thirty years since the Royal Commission on Mental Health and the Mental health act, the philosophy and emphasis has been on helping people help themselves to lead more fulfilled lives — “an enabling approach.” [Browning 1992, p. 40]

This approach involves a greater recognition of the role the patient can play in the determination of care and the definition of needs through a process of consultation and involvement. Although these documents and papers often support the concept of patient participation in the process of care planning and assessment, in practice it is questionable whether it has actually attained the high profile intended for it.

People receiving community care are not “cases” in need of being managed; they are citizens with rights to privacy, dignity and self determination. Issues of user advocacy and user involvement have to be taken seriously if community care services are not to repeat the patterns of stigmatizing institutionalization which have inadvertently worked to block individual independence and the growth of mutual support and solidarity among mental health service users. [Conlan 1992, p. 62]

Thus, some feel that although major steps have been taken in terms of advocacy and patients' needs, this area still requires further development and a greater level of awareness (see also Barker and Peck 1987).

The concept of empowerment can also be tackled on a more philosophical level by considering further the relationship between psychiatry, conceived as a discourse, and the conception of

patients, or, in other words, the subjectivity of the patient. For Foucault, the historical objectification of the mentally ill by psychiatry was closely linked to a form of cruelty: "It might be said that all knowledge is linked to the essential forms of cruelty. The knowledge of madness is no exception" (1970, p. 73).

Indeed, the institutionalized abuse of patients provided much of the impetus behind movements such as that of the anti-psychiatrists during the 1960s. Further, the shifting conceptions of the patient, and the competing discourses on which these depend, indicate the changing constitution of subjectivity rather than the discovery of the "truth" of mental illness.

In scrutinizing the consequences and implications of accepting the patient-as-person, the discourse has fabricated that same patient. This "whole person" is therefore the product of a series of smaller discourses (on compliance, communication, etc.) which, though intertwined with one another, have contributed separate elements to the final perception of the patient: a "subject" imbued with personal meanings, constructs, feeling, subjectivity, etc. The whole person is a multi-dimensional rather than a unitary being. [Armstrong 1982, p. 119]

This line of argument is crucial to any debate about empowerment. Put starkly, does it remove the repressive controls on an otherwise free subject, the inner essence of the human being, or does it presuppose and also constitute a new form of subject — the empowered patient? Any assessment of empowerment has to question the assumed ontological status of the subject to be released from the repressive regime. Is the patient to be liberated by modern mental health services or constituted by them? In Foucault's terms, we cannot speak of empowerment *per se*, of emancipating the subject as such, but only of the shift from one regime of "truth" to another.<sup>5</sup>

The assumed subjectivity of the patient within different discourses has been complemented by the development of the techniques of clinical practice deemed appropriate to each. "The clinical examination was a device for ordering bodies which, in doing so, constituted them; the medical interview and relationship has become a comparable mechanism for analyzing, and thereby constituting, idiosyncratic patients" (Armstrong 1982, p. 119).

Thus the discipline of psychiatry has developed a whole battery of technologies for inspecting, calculating, controlling, and even operating on the human psyche. This is similarly illustrated by the case of psychological models for diagnosis and assessment:<sup>6</sup>

They enabled human powers to be transformed into material that could provide the basis for calculation. The examination formed the model for all psychological inscription devices...[and] combined the exercise of surveillance, the application of normalizing judgement and the technique of material inscription to produce

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<sup>5</sup>However, the extent to which these developments reverse the great exclusion so long carried out in the name of psychiatry and thus allow the reconciliation between reason and unreason remains an open question.

<sup>6</sup>It may be objected that psychiatry and psychology cannot be equated. However, while they are certainly not the same, neither are they easily separable.

calculable traces of individuality....The psychological assessment is not merely a moment in an epistemological project, an episode in the history of knowledge: in rendering the subjectivity calculable it makes persons amenable to having things done to them — and doing things to themselves — in the name of their subjective capacities. [Rose 1990, p. 7]

The development of the different forms of technologies within psychiatry can be seen as devices not only for inscribing and codifying individual attributes, but also as systems for conceptualizing and calculating human subjectivity. They render the subject open to calculation and classification through various strategies and complex mechanisms of power.

We contend that recent changes in the management of mental health services represent interesting developments as far as this line of argument is concerned. In addition to the subjectivity of the patient, we wish to consider management as a disciplinary body of knowledge and techniques, one which increasingly revolves around information and the management of information, the subjectivity of managers and other health professionals, and also the role allotted to IT as a condition of possibility for empowerment — either for management or patients. To the extent that the efficient and effective provision of mental health services have come to be seen as problems of information, then those services have become constituted as objects of information management. Conceiving of mental health services in such terms opens up a space for managers and other health professionals to seek to intervene and exert some control over the nature of those services — precisely through the management of information.<sup>7</sup> Moreover, to the extent that the patient participates in their own assessment, they thereby help initiate important information processing and decision making procedures constitutive of their case.

## **5. CARE IN THE COMMUNITY: INFORMATION, MANAGEMENT, AND ACCOUNTABILITY**

The development toward care in the community was accompanied by a general feeling of apprehension within the Department of Health and other agencies regarding accountability and “control” associated with the behavior of out-patients who may have previously been admitted as in-patients (and therefore securely locked away from the general public). Thus the concepts of control and accountability were presented as fairly important features associated with good clinical practice within the literature associated with community-based systems of care. These include approaches and systems that have increasingly inscribed the patient within an informational context — through encoding, categorizing, and representing — as a result of the introduction of varying technologies for out-patient care, care planning techniques, and information systems that maintain documentary records of patient details. For instance, the management of out-patients includes the diagnosis of certain patients as having complex and long term mental health needs in the form of access to rehabilitation programs, the continued prescription of certain drugs and medication, psychotherapy techniques, and residential units.

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<sup>7</sup>There is a complex history pertaining to the relationship between medical practice, health care and computers. For instance, Kaplan (1995) explores this relationship in terms of dreams and visions that are tied into a “mythical charter” which is instrumental in gaining support for particular programs of computerization and which shape how these are subsequently developed and implemented.



In particular, the Care Programme Approach (CPA) is a mandatory and binding requirement launched by the Department of Health (Department of Health 1990).<sup>8</sup> It calls for a “system to ensure that in future patients treated in the community receive the health and social care they need.” It also states that the aims of the CPA involve

Introducing more systematic arrangements for deciding whether a patient referred to the specialist psychiatric services can, in the light of available resources and the views of the patient and, where appropriate, his/her carers, realistically be treated in the community...ensuring proper arrangements are then made, and continue to be made, for the continuing health and social care of those patients who can be treated in the community. [Department of Health 1990, p. 23]

The CPA is acknowledged to have played an important role in discussions regarding the reorganization of the management and delivery of mental health services:

In addition to establishing systematic arrangements for assessing health and social care and ensuring that the relevant services are provided, the care programme approach initiative has acted as a catalyst for discussion and evaluation of a wide variety of related issues. These include multi-disciplinary and inter-agency working, the role of users, carers and voluntary agencies, the impact of the organization of health services (for example sectorization) on discharge planning and the role of computerized information systems. [North and Ritchie 1992, p. 108]

One of the factors widely seen as central to care in the community is IT. Thus a number of documents have stressed the importance of developing computerized information systems to ensure the successful implementation of the CPA (Challis et al. 1990; Cambridge 1992; Onyett 1992). “In a recent study on the implementation of the care programme approach, delays in the installation of computerized systems to deal with the information collected was a barrier, particularly in the monitoring process”(North West Regional Health Authority 1993, p. 14).

Some of the underlying themes associated with this desire for a greater level of information include the feeling that with the right policies and technologies, resources will be distributed more fairly according to patients’ needs. This is supported by Cambridge (1992) who suggests that

departments are recognizing the need to build good service utilization and cost management information systems, which will help formulate answers to equity questions at the client and service levels, and provide information for cost-effective individual service planning and community care planning more generally. [Cambridge 1992, p. 19]

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<sup>8</sup>Health Circulars are part of the documentation provided by the Department of Health. They contain directives and guidelines which aim to ensure that each hospital follows a particular way of introducing new measures or initiatives in the prescribed way.

Such developments include the deployment of information systems for use in the process of coordinating and allocating resources to patients by selecting from a wide range of options in a preset menu (Onyett 1992, p. 9). The needs assessment form (see appendix) provides a good illustration of preset options in the way that the selection of needs are restricted to those defined within the form. The process assumes that by establishing which of these needs are unmet, resources can be allocated more efficiently, while the task of resource rationing provides an image of an effective and equitable system of assessment and allocation.

A major contributor to the needs assessment process is the *keyworker*. This role has been created within the CPA to ensure that needs are assessed and suitable care plans are produced using a multidisciplinary approach and in accordance with the patient's wishes. Therefore, the allocation of the keyworker role to the professional group, such as a community psychiatric nurse or a social worker, will depend on the case in hand. One of the goals of the information system within this process is to enable the needs assessed by the keyworker and the patient to be categorized and represented in a graphical form (Onyett and Cambridge 1992). This is meant to ensure that unmet needs which require additional funding and support are highlighted. Specifically, unmet needs are derived from the concept of the *needs-led* approach to clinical care: if the "actual" needs of the patient as revealed by assessment cannot be addressed within the multidisciplinary approach to care, then these needs are recorded as unmet. The importance associated with the need to document unmet needs reflects the increased level of accountability and efficiency associated with the allocation of resources within the internal market and the perceived need to argue for additional resources.

Moreover, the issue of accountability has extended the role of monitoring and reviewing patient care and supervision to an "at risk" register (NHS 1994). Implemented as an information system, the official purpose of the register is to form an electronic "safety net," to prevent patients within the care in the community program from escaping the control of mental health professionals and either harming themselves or others. In practical terms this has put pressure on psychiatry departments to prove that their systems satisfy the national requirements — that is, that their safety net is in place.

## **6. INFORMATION AND NEEDS: EMPOWERMENT AND PARTICIPATION IN PRACTICE**

The psychiatry department in which our research is based is located within a large teaching hospital which operates as an NHS Trust (that is, it is self-governing). The research has been ongoing over the past two years. In addition to the analysis of texts — including official government White Papers, mental health acts, policy directives, research studies, care models, and internal documents — it has also involved interviews and participant observation. In particular, one of the authors became a member of the CPA Audit Team within the psychiatry department and took on the responsibility for producing an audit report to assess the "efficient" and "effective" operation of CPA within the hospital.

Until the advent of the CPA, the main information system within the department had been a database of patient records. This system records all patients in contact with the psychiatric services and is updated each time the care setting of the patient changes.

A range of patient specific information is essential to any understanding of the effectiveness of treatment....Analysis of the data collected is also important in enabling staff to think more coherently about the services offered and to plan and evaluate new provision effectively. [Psychiatry Department *Information Systems Overview*]

However, this system was viewed by those involved in assessing the information requirements of the department (principally the Information Manager) to be unsuitable because of technical problems associated with providing a system that would support community care, and in particular a needs-led approach to clinical care. This was thought to be particularly problematic in the light of the CPA and the need to implement the supervision register. Moreover, other initiatives were beginning to place increasing demands for information, for example, in the area of medical costing, research, joint planning with social services (in line with the Department of Health directives) and medical audit. While a stand alone system was required to support the CPA initiative, the department was also going through a process of selecting another clinical and management information system based around the principles of the CPA and case management techniques. Here we will refer to this information system as the Care Manager system.

While the general feeling within the department reflects a positive view toward the CPA and the proposed Care Manager system, some have expressed reservations: could the CPA unite the services and what role would it play in terms of clinical care? As one Consultant Psychiatrist expressed the matter:

The good thing about the system is that the clinicians seem to feel that the information is useful so you are more likely to get reliable information at the end of the day. I'm not so sure how useful the information really is for clinicians though as it seems more appropriate to administration and monitoring than clinical care. [Interview with Consultant Psychiatrist, September 1994]

Consequently, although the CPA and the Care Manager systems were presented as a way of integrating the care of patients in a systematic and coordinated way within the whole program of care planning and management, some questioned the assumption that any approach or system has the ability to determine and perform this form of integration within the network of clinical practice. "There is the expectation that pieces of paper (the CPA and the information systems) will weld together a service that is structurally disparate" (Interview with Consultant Psychiatrist, September 1994).

## **7. NEEDS ASSESSMENT**

There were also numerous claims and expectations linked to the notion of empowering both patients and mental health workers through accountability and support, needs-led assessment and informed choice. These were expressed both in official documents (Department of Health and Social Security 1989) and in CPA meetings at the hospital. In accordance with the needs-led community based system of care, there had been a feeling that the style of treatment associated with asylums and institutions should be replaced with individualized care. This was to be provided on a continual basis and with the participation of patients in the assessment of their

needs. The latter forms a major component in the derivation of care plans. While the assessment of the in-patient's needs can be performed within a pre-discharge meeting attended by a multidisciplinary team, or prior to this meeting by the ward nurse, the out-patient procedure is different. In this case, the location of the needs assessment may be carried out in a variety of settings: in the patient's home, a day hospital, a rehabilitation center, or a consulting room. Whatever the location or the status of the patient (in-patient or out-patient), the keyworker should perform the needs assessment evaluation in association with the patient and then transfer the information onto the needs assessment form, which (in this department) is generated by the CPA system. The needs assessment form (see appendix) is designed to encourage the adoption of a needs-led approach through the continual monitoring of patients' requirements: by separating and then codifying their needs into a range of categories. Thus, the needs assessment form contains basic details about the patient, keyworker, and the general practitioner etc. It also provides a list of over twenty different categories of needs, including social, cultural, day care, support, accommodation, and advocacy needs.

The central rationale underpinning the needs assessment is the idea that the needs of the patients go beyond "clinical" needs and include those associated with their "social," "cultural" and "practical" requirements (for example, in terms of income, accommodation, domestic and social support, carer's needs, and training). Once the needs assessment form is completed, it is sent to the CPA coordinator and the information is transferred onto a database which enables the identification of the unmet needs.<sup>9</sup> This information system has the facility to identify future review dates (when patients' cases are reconsidered) and it also provides graphical representations of unmet needs. It is seen to be useful to management not only for identifying the specific needs that are unmet but also the services that are seen to be under funded.

The CPA can be used to inform the planners where more resources are required. For example, in the case of rehabilitation certain services are seen as very effective ways of improving the quality of life of the chronically ill, but they need more funding. [Consultant Psychiatrist, CPA Audit Meeting, August 1994]

The procedure for generating and processing information associated with care planning and needs assessment has been met with a variety of reactions from mental health and social service workers. Some view it merely as a paper-pushing exercise that appears to provide no real benefit for the service: "I'll continue to go through each of the unmet needs with the patient and tick the relevant boxes on the form, but I don't see the point in it" (Acute Psychiatric Nurse, CPA Audit Interview, August 1994).

Others see the process of determining needs in this way as problematic because it is entangled within a web of very difficult issues concerning diagnosis and clinical care. Thus within the needs assessment process the role of the patient is further complicated by the divergence of opinion regarding the role of the "expert" in the assessment of needs, as opposed to the participation of

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<sup>9</sup>In other departments at hospitals elsewhere, additions and variations to the assessment have included a scoring system attached to determine the need for care management — these having been criticized for conflicting with clinical judgment. Other areas have been keen to develop a "common dependency assessment" which would provide assessment criteria that could be used by a wide range of professionals from both health and social services.

the patient in the construction of their care plans. When does the view of the individual become superseded by the opinion of the “professional” and who should have responsibility over the coordination of services for patients? As one manager expressed the matter:

There can always be conflict in decisions concerning the care and treatment of the patient. We have one case here where there is a disagreement over whether a patient should receive psychotherapy....Ultimately, you have to rely on the judgement of the expert....It’s a bit like when you take your car to be serviced and you have to rely on the mechanic for their advice on what needs fixing. [Service Manager, CPA Audit Interview, September 1994]

The issues involved here came to a head during a departmental review of the CPA in August 1994, when a hypothetical case was raised in order to flesh out the problems of determining patients’ needs. One consultant psychiatrist felt that in certain situations a variety of interpretations concerning the needs of the individual could be produced depending on the judgment of the person assessing the unmet needs: “What would happen if you had to assess the needs of an individual living alone in a flat and surrounded by neighbors who are seen as a threat to them (that is, the patient) in some way?”

In order to provide some form of documentary evidence based on the situation above, it was accepted that an assessment of the patient’s *real* needs would be required. From the patient’s perspective, they may view their problems as deriving from their housing needs — that is, they needed rehousing. However, if they were diagnosed as schizophrenic, their feelings about their neighbors may be seen as delusional and so in this case the *real* unmet need could be seen from a more clinical perspective. Accordingly, a second consultant psychiatrist at the meeting suggested that “It wouldn’t be possible to rehouse every patient with delusions about their neighbors and anyway this wouldn’t address their real needs, which isn’t housing.”

This line of argument was supported by a ward manager who felt that “addressing the issue of accommodation as an unmet need merely reinforces the patients delusional fears of their neighbors. Rehousing would not help the patient deal with these delusions and it could actually make the situation worse.”

Thus within the process of interpreting unmet needs there appear to be major obstacles concerning the diagnosis of *real* needs. While some supported the view that in this case the patient’s view of their needs was based on delusions and should therefore be ignored, others present at the meeting took an opposite position. The latter felt that in this case the assessment should be based on the patient’s perspective — this being the hallmark of patient-centered care. The belief that the patient’s perception of the situation should be followed was neatly summed up in the following comment a Community Social Worker: “Even if the assessor feels that the patient’s perception of the neighbors as a threat is based on a delusion, the need for new accommodation is a real one to them and should therefore be treated in that way.”

The interchanges and issues arising in this episode stress the variety of interpretations associated with the role of the patient and that of the experts (that is, the health and social services professionals) in the assessment of needs. What must also be highlighted is the role of the specific

discursive practices within the whole process — namely, the completion of the needs assessment form. We need to consider how the *writing* of the form, and the wider information system which it feeds, may shape clinical practice and relationships between patients and experts within psychiatric care (Smith 1978). In this particular case, this involves examining the notion of empowerment in relation to the way that the needs assessment forms are constructed in such a way as to facilitate the categorization of unmet needs within the overall information system, as well as the monitoring role delegated to this technology.

## 8. THE SUBJECT AS PATIENT

The aims and objectives of the purchasing Health Authority, in which the psychiatric department operates, states that individuals and communities should be empowered so that they can take action to improve their own health.

By empowered individuals we mean individuals who: have the appropriate information on health and health services; can make informed choices; are consulted about the health care options available to them; feel as though they are in control over their own lives. [Health Authority *Aims and Objectives Plan* 1994]

Both the CPA and the subsequent implementation of information systems that contain patient and service information are seen to support these claims of patient empowerment: by facilitating an increased level of patient participation in the determination of needs and by the provision of a continual and coordinated service of clinical care. Hence, this presupposes that a more *accurate* and *true* representation of the patient's needs can be achieved through an increased level of participation in the needs assessment process. In turn, this is based on the problematic assumption that the patient has the capacity to make "informed" and therefore (by implication) rational "choices." We are not dealing here with the sovereign subject of rational choice theory — indeed the patient is assisted by the keyworker in the exercise of choice. Nonetheless, the assumption of "informed choice" and feeling "in control of their own lives" still relies upon a notion of rationality within the needs assessment process. A central problem here is that such rationality is not a *condition* of participation but, rather, is *constituted* by it (see also Mullender and Ward 1991). Of course rationality in a wider sense is also presupposed by participation. That is, a patient who declares them self to be a Martian in response to every utterance of the health service professionals would presumably be deemed unable to participate in the needs assessment process and therefore could not be empowered.

What we are dealing with here is a technology of needs assessment; a technology based on a specific discursive practice that — in the terminology of Akrich (1992) — contains an implicit script. This applies both to the patient, whose needs are to be determined, and the mental health professional, who is to intermediate between the patient and the wider system of care. As regards the patient, this script calls for an informed individual able to make choices and this provides the key to understanding the nature of participation and empowerment in this context. We are not dealing with participation and emancipation *per se* but the constitution of these terms in the specific way afforded by the practice involved. This is not a condemnation of these varieties of empowerment and participation so much as an articulation of their particular character. To put

things simply, a patient might wish to be better and to express this during the needs assessment exercise; however, this is not a *choice* which is open to them in the sense of a deliberate action that they might take. In other words, the assumption and constitution of rationality through the exercise of choice operates through pre-given categories over which the patient has no influence. Their sense of “control over their own lives” may extend to the sorts of choices they can make within the range of options on offer, but it does not include the discretion to exert control over their illness. It is also worth pointing out that the notion of empowerment sits uneasily with that of case management which is similarly seen as central to the management and delivery of care. Following the publication of the *Caring For People* (Department of Health and Social Security 1989), the term “case management” was felt by some patient groups to be an inappropriate way of addressing individuals in the community insofar as it appears to reinforce the position of the patient as merely a *case* to be worked on by mental health and social service employees — as opposed to an empowered subject (Onyett and Cambridge 1992). As a consequence, there was a general move within the mental health services to adopt the term *care* management rather than case management.

The increased visibility of patients’ actions as constituted through their participation in the formulation of care plans and the definition of unmet needs can also be seen to impose a degree of accountability on the individual. That is, having participated in the needs assessment process, with the implicit rationality of choice defining a sort of logic of their situation, they can later be called to account should their behavior or future expression of needs conflict with their earlier choices. That is, changes which cannot be accounted for may thus come to indicate a lack of reason.

Additional problems pertaining to the needs assessment exercise have also been identified in relation to patients’ perceptions of the keyworker role in satisfying their needs. Where the role is seen as powerful one, the patient may feel that their views are sometimes not acknowledged or taken into account and, therefore, they tend to withdraw from participating fully in the process. A role perceived as weak, however, may project an image of token backing and the feeling that nothing has changed regarding user involvement and support.

For the service user the stark choice of heads I lose and tails you win, is all too familiar one in a world where information, like power and resources, is a very scarce commodity. The right to make informed choices more often belongs to the world of rhetoric than reality. [Conlan 1992, p. 65]

This sentiment was also echoed by one of the department’s service managers:

Information is knowledge but not power, as power is still in the hands of the establishment....We are merely agents of social control....We never provide patients with power we just provide them with more information. It’s a bit like saying that you could offer the criminal fraternity more information about different courts, types of judges and prisons, because at the end of the day you are still going to detain them against their will. [Service Manager, informal discussion, January 1995]

The option of caring for patients in the community and allowing them to participate in the derivation of their care plans is presented as a move toward a more preferable process of clinical care — and indeed, who would defend the system of incarceration of the asylum? However, we have to recognize how the changing practices of clinical care still represent a particular regime of truth, one which constitutes subjects and renders them visible and open to calculation in a specific way.

## **9. THE SUBJECT AS INFORMATION MANAGER**

Turning now to the professionals who work with the mentally ill, we find that the CPA system is also seen as a means to empower keyworkers. In particular, this empowerment is seen to reside in the provision of a system of procedures that provides a standard and structured way of assessing the needs of the patient within a framework of informed choice. This presupposes that by providing keyworkers with a comprehensive list of services, they would be able to make informed decisions regarding the aftercare of the patient and would subsequently ensure the provision of a more effective service for them. While some feel that the systematic and standardized design of the needs assessment form limits the flexibility and interpretive ability of psychiatric workers — for instance, by restricting the choice of categories in which to assess patients' needs — others believe that the assessment form could actually expand the interpretative skills of the mental health or social service worker. In particular, it could provide them with a greater appreciation of different needs and services through informed choice. "The keyworker is empowered not only through informed choice, but also in the way that the needs assessment process and the care plan provide a well documented and structured approach to care planning" (Care Plan Coordinator, CPA Audit Meeting, January 1995).

Therefore, although the format of the needs assessment exercise may be viewed by some as a desirable way of recording patients' details to enable the information to be processed and classified in a way that will facilitate analysis and accountability, it can also be seen to play a role in constructing practice. Specifically, a keyworker may be a nurse, a consultant psychiatrist, or indeed someone from social services, but whatever their professional background, keyworkers have something else in common — namely, they are constituted as information managers. The conceptualization of what they do is mediated by the demands of information processing — both in terms of needs assessment, in order to carry out their role as keyworker, and in terms of documenting accountability and the effective discharge of their role.

One issue particularly emphasized by those involved in the introduction of the CPA system is the subsequent impact this approach has had on the administrative duties of the workers involved. This has been felt from both sides of the mental health and social services division and in particular by the social workers, community psychiatric nurses and consultant psychiatrists. For example, consultant psychiatrists feel that the increased level of paperwork and workload involved in completing forms, assessing patient needs, arranging team meetings, and the general increase in organizational responsibilities, has restricted the time available to actually care for the patient. "There is an opportunity cost. As we spend more time filling in forms there is less time available for patient care" (Consultant Psychiatrist, CPA Audit Meeting, October 1994).



Underlying administrative regimes such as the CPA are a variety of assumptions related to the concepts of accountability, communication and coordination. For example, in the case of the managers of this information there is the presupposition that by making themselves more accountable in terms of patient care and the provision of services they also open up a whole new space for action. Indeed, changing practices and the implementation of the CPA system have led to the creation of new positions — including the keyworker. A major part of this role, together with that of the care plan coordinator, is the management of information including patient care plans, the assessment and recording of client needs and the coordination of multidisciplinary teams. Upon inspection of the needs assessment form, one observes that the process of identifying unmet needs appears as a checklist: for each category, the needs are either unmet or not. Note that upon identification of an unmet need, no specific action or solution is represented in this form; the information is gathered in order to reveal an overall picture of unmet needs within the population for which the department has service contracts with purchasing health authorities. Rather, the actions which follow the identification of unmet needs are mediated and reinforced by another writing instrument — namely, the care plan. Although the information on unmet needs feeds into, as it were, the formulation of the care plan, the discursive separation of the two procedures reinforces the importance of information and information gathering within organizational practice.

## 10. DISCUSSION

This paper has sought to address the relationship between empowerment and IT in the specific context of the management and delivery of mental health services. We have not aimed to show the *impact* of IT on either organizational practice or mental health patients. Rather, the analysis of the developments in our case study psychiatry department indicate that the roles assumed for the keyworkers and patients are a *condition* for the operation of technology, not a consequence of it. Thus empowerment — either of patients or health professionals — is not a consequence of the introduction of IT but is constituted through the development and implementation of this technology in specific ways. For patients, empowerment is a matter of making informed choices: the subject is not liberated by technology but constituted as an empowered subject to the degree that they “participate” in the needs assessment exercise and formation of care-plans. For the health professional, empowerment centers on the increased organizational visibility and span of control/accountability opened up by practices of information gathering and management. In each case, the discourse of empowerment is pitched at the level of individual subjects but, following the line of argument developed here, it should be apparent that particular forms of organizational life are being promoted and reinforced: empowerment for individuals presupposes a world of rational organization dominated through, and on, paper in the shape of the forms central to needs-assessment and care-planning.

Moreover, the various actors involved at our case study hospital have been actively engaged in shaping the construction of the technology — for instance, the needs assessment form and the care plan form. It was almost inevitable that new IT systems would be introduced, not only because of Department of Health directives but also because management in the psychiatry department had been proactive in the area of IT for some time. However, the actual characteristics of the IT systems when implemented, and thus in live operation, not to mention their ongoing maintenance and extension, are not predetermined by any technological imperative. Similarly,

although keyworkers have become managers of information — a role inscribed in the IT system — the matter of what counts as information, as well as the meaning of the changed organizational/health service practices which it mediates and reinforces, is not pre-given but actively constituted. Thus the implementation of the Care Programme Approach differs between different mental health service provider units. As the exchange of views regarding the needs assessment form indicates, its meaning even within one site is subject to interpretative flexibility.

Finally, one role that needs further consideration is that of the information systems — the CPA system and the Care Manager. What is of particular interest here is that in parallel to the notion that keyworkers are empowered through their access to, and use of, the IT systems, it is also evident that certain aspects of organizational control have been “delegated” to those systems (Latour 1992). The task of monitoring the care planning process — such as highlighting review dates, recording the responsibilities and duties of all those associated with the patient’s care, and displaying warnings when workers have failed to meet target dates or information requirements — has been automated. This implies that there will be less direct management of the operational information by the keyworker and care plan coordinator. The onus on psychiatry departments to establish systems of control *vis-à-vis* patients in the community depends on the cooperation of the keyworkers and other staff in playing the roles inscribed for them in the information system, but the responsibility for such control has been delegated to the IT system. The future implications of this for organizational practice — both in terms of management and psychiatry — will be interesting to follow.

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**APPENDIX: EXAMPLE NEEDS ASSESSMENT FORM**

no: [REDACTED]	No:	Today:
Ward/Team_no: [REDACTED]		Date on caselink:
		Date last change:

  

Client details First names: [REDACTED] Surname: [REDACTED] Address:  Postcode:	Date of Birth: Over 70?: NO Age Band: [REDACTED] Over 65?: NO Gender: [REDACTED] Ethnic Origin: N/K [REDACTED] Locality: Social Services Area: Date last care plan: Date last review: Date next review: SECTION 1177: N/K Client agreed:
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Source of info: Any needs unmet?: N/K Does this person have a Key Worker?:	2nd contact: Telephone no.: [REDACTED] Address:  Postcode:
--	--

  

Discharged?: NO      Date: Discharge reason: Discharge detail:	G.P. Name.: [REDACTED] Consultant: [REDACTED]
--	--

Memo:

- UNMET KEY WORKER:
- UNMET PERSONAL CARE:
- UNMET CULTURAL NEEDS:
- UNMET INFORMATION NEEDS:
- UNMET MEDICATION NEEDS:
- UNMET COMMUNICATION NEEDS:
- UNMET TECHNICAL AIDS NEEDS:
- UNMET CARERS NEEDS:
- UNMET RESPITE NEEDS:
- UNMET ACCOMM. CHANGE:
- UNMET ACCOMM. SUPPORT:
- UNMET DOMESTIC SUPPORT:
- UNMET TRAINING/EDUCATION:
- UNMET SUPPORT:
- UNMET EMPLOYMENT:
- UNMET COUNSELING:
- UNMET ADVOCACY:
- UNMET SOCIAL:
- UNMET FINANCIAL:
- UNMET THERAPY:
- UNMET TRANSPORT: