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Wibberley, C and Murphy, N

<http://dx.doi.org/10.1080/14623943.2016.1184633>

<b>Title</b>	The influence of the media on practice in mental health : a bricolage of a single case study
<b>Authors</b>	Wibberley, C and Murphy, N
<b>Type</b>	Article
<b>URL</b>	This version is available at: <a href="http://usir.salford.ac.uk/39235/">http://usir.salford.ac.uk/39235/</a>
<b>Published Date</b>	2016

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**Christopher Wibberley & Neil Murphy**

Authors' copy of article published in **Reflective Practice: International and Multidisciplinary Perspectives**

<http://www.tandfonline.com/doi/abs/10.1080/14623943.2016.1184633>

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**The Influence of the media on practice in mental health- a bricolage of a single case study**

Abstract

This paper has its genesis in the convergence of two individuals' interests - one with a long standing interest in representations of mental health and one with an interest in the use of bricolage as a research approach. These interests converged around the ways in which mental health care practitioners might react to and subsequently reflect on images of mental health they came across in the media. A bricolage was developed relating to newspaper coverage of a homicide carried out by someone with a mental health problem. The bricolage draws on the assumption that practitioners will have immediate reactions to material they come across, take a more considered overview of this material and subsequently attempt to contextualize this reflection in terms of academic literature. The bricolage as presented mirrors this process for an experienced practitioner. Suggestions are made concerning the use of newspaper reports on mental health, to enable both novice and experienced practitioners to gain vicarious experience through reflection on these reports.

Key Words: reflective practice, bricolage, mental health, media, risk assessment.

## **Introduction**

The genesis of this paper lies in the convergence of two individuals' interests. One had an interest in mental health and the media – and the potential impact of the media (and particularly newspaper reporting) on mental health practitioners. The other had an interest in the use of bricolage as a research approach to practice-focused inquiry in health and social care. These interests converged around the ways in which mental health care practitioners might react to and subsequently reflect on images of mental health that they came across in the media, particularly newspaper reporting. Initial reflection and discussion between the two individuals suggested that the most memorable reporting related to homicides carried out by those with mental health problems, which was borne out by an initial exploration of media reports (Murphy, Fatoye & Wibberley 2013).

The vast majority of people only ever gain experience of homicide through vicarious experience, which may well be through television or film providing fictional accounts of killings. These vicarious experiences we know are fictional; that we perceive these events as entertainment reinforces this. More fact-based accounts may well be accessed through news reports in various media. Whilst both fictional and fact-based accounts may well impinge on our view of homicide, fact-based accounts may well be given greater credence in the way we conjure up such a view. The view created from whatever accounts we access, may change our pre-existing views and opinions and subsequently actions.

The influence of media reports of homicide, on varying audiences, remains relatively under-researched (Shaw 2010); however, there remains an assumption that sensational headlines will catch the attention of any reader and engage them in identifying what the risks presented in the story may mean for them. The mental health care practitioner may not differ greatly from the lay person in his or her vicarious experience of homicide itself. However, a mental health care practitioner, especially if working in the forensic sector, may come into contact with those who have carried out violent acts, including killing. The question, therefore, arises as to what impact vicarious media experiences have on such

practitioners and their subsequent behaviour in caring for those with mental health.

Previous studies investigating the representations made of mental health in the media, have explored coverage in terms of its stigmatizing nature. These studies have suggested that the mentally ill are represented, inter alia, as different, unpredictable, unable to care for themselves and in particular, criminally violent (see for example: Cutcliffe & Hannigan, 2001; Rasmussen & Hoijer, 2005; Sieff, 2003; Stout, Villegas & Jennings, 2004). That such coverage acts to reinforce stigmatization is suggested by Sieff (2003) amongst others.

Studies over a number of years have explored the effect of media coverage of those with mental health problems on the public's perceptions of mental health and of those with such problems (see for example Appleby & Wessley, 1988; Crisp, Gelder, Rix, Meltzer & Rowlands, 2000; Philo, McLaughlin & Henderson, 1996; Stuart, 2006). The findings of such studies suggest that mental health service users felt that their self-definition, self-esteem and recovery were impaired by the content of such coverage. Public opinion was influenced by: how recent the coverage was; the perceived severity of the incident reported; and how someone diagnosed with a particular condition was perceived and categorized. Similarly studies have explored the impact of such media coverage on policy making (see for example Hallam, 2002; Paterson, 2006). These studies suggest that policies have become more coercive and constraining on the mentally ill, potentially as a result of media coverage.

What has been little explored in the past, is the impact of media coverage of those with mental health problems on the practitioners who are charged with caring for them (Murphy et al., 2013). It is the impact on a practitioner that the present paper will focus on. Such a study is appropriate in particular, given as Warner notes

Homicides by people with mental health problems are presented in the media as an outcome of the failure of community care policies to contain 'dangerous people' ..... and of individual professional incompetence.

(Warner, 2006 p226)

A small number of homicides carried out by people with mental health problems have been reported extensively in UK national newspapers over the last 25 plus years (the UK being the location in which the study was based). At the time the study was planned, Peter Bryan was the last of these cases for which an Independent Inquiry had been published. Thus it was decided to adopt coverage of the trial for this particular homicide as a case study. Newspaper coverage of the final day of the court case was selected for analysis (i.e. after reporting restrictions would have been lifted) along with the Independent Inquiry.

## **Methodology**

Bricolage is a relatively little used approach to research; with fewer exemplary texts and less of an established tradition for researchers to draw on in coming to an understanding of the approach (Wibberley, 2012). However, from a selection of potential exemplars of bricolage (Denzin, 2008; Haw, 2005; Lather & Smithies, 1997; Markham, 2005; Mol, 2002; Rambo Ronai, 1995) it can be considered as a research approach which involves bringing together different sources of data (usually a relatively diverse range of data). Decisions are made in developing a bricolage, so that the result is a deliberate process of placement/positioning of the material; which potentially influences the way in which meaning is constructed by the reader. Some of these decisions imply an ordering of the text that the reader should follow (see for example: Haw, 2005; Markham, 2005; Rambo Ronai, 1995); whilst others infer that such a decision should be made by the reader, with text juxtaposed against other text (see for example: Lather & Smithies, 1997; Mol, 2002).

Wibberley (in press p179) has noted ‘different data sources can be layered, placed on specific parts of the page, used as inter-texts (which divert from the main text) or deliberately juxtaposed to fragment or splinter reading. Alternatively the different data sources can be reworked into a different (and artistic) form such as fiction, poetry, drama and/or visual imagery’. In terms of these types of use of data sources, we can be seen to be adopting a layering approach. Such an approach in many ways draws as much from the

tradition of auto-ethnographic reflection (see for example: Ellis 2004; Denshire & Lee 2013) as it does from bricolage per se. The examples of bricolage (Markham, 2005; Rambo Ronai, 1995) used as exemplars use reflexive / reflective comment alongside other material - this reflection forming a commentary of sorts on the other material.

We decided to order the text in line with how, as practitioners, we might actually reflect on reading media reports. Thus we adopted a relatively conservative form of layering which also ensured that content was not overshadowed by process. Decisions about ordering of text and inclusion of a range of texts also attempted to ensure reflection went beyond superficial discussion – a process which Thompson & Pascal (2012) considered critically as sometimes passing for reflective practice by professionals – but was also feasible for practitioners to undertake. Thinking about how practitioners reflect, most will have immediate reactions / initial impressions of material they come across. Hopefully, they will then take a more considered overview of this material based on more detailed reading of the material itself and reflection on how this material relates to their experience and tacit knowledge. Finally, they may then attempt to contextualize this reflection in terms of appropriate evidence as provided by the literature (quite possibly drawn from limited, favoured, sources). The bricolage as presented, attempts to mirror this process in a recursive manner; layering multiple consideration of the events depicted in the newspapers by one or both authors.

The bricolage draws on the following three elements:

- newspaper coverage from the final day of the trial of Peter Bryan in March 2005 (at which time reporting restrictions would have been lifted) along with the report of the Independent Inquiry into the care and treatment of Peter Bryan (Mischon, Exworthy, Wix, & Lindsay, 2009);
- practitioner reflection on the coverage of the trial and the report of the Independent Inquiry;
- selective academic and quasi-governmental literature.

As presented the bricolage is an interplay of these first two elements (in primary and secondary reflections) with the third element being introduced only within the tertiary reflections (see below). The tertiary reflections differ from the other reflections, in that extracts from academic text is layered into / after reflection as opposed to reflection being triggered by and thus layered after the text. Academic text is being used here as a form of data, although by using text in this way, a discussion of sorts is also initiated. Newspaper coverage was taken from all national UK newspapers available in online editions, accessed through the LexisNexis Butterworth database.

## **Results**

### ***Results: Initial Practitioner Reflections #1 (Primary Reflections)***

We had read and re-read newspaper reports on the trial of Peter Bryan. This left one of us angry, and the other somewhat sad. We re-read the opening lines of the newspaper coverage and then reacted to some of them as indicated below. These reactions (primary reflections) being recorded as joint commentaries. The opening lines seemed to relate to four different ‘themes’: mistakes and manipulation, attempting to make a balanced decision, perceived effects on others and reinforcing the stereotypes. Opening lines followed by reaction to them are presented below under these four themes.

#### *Theme 1: Mistakes and manipulation.*

Despite the chilling menace posed by 35-year-old Bryan – a known killer supposedly under the care of Britain’s mental health system – he was allowed to roam free. He walked out of a hospital hours before he butchered pal Brian Cherry with a claw hammer and screwdriver.  
(Hepburn, 2005).

A mental patient who got a ‘thrill and feeling of power’ from killing and eating his victims was free to carry out his crime thanks to a ‘manifest failure’ in his treatment, the Old Bailey heard yesterday . . . . The court heard he fooled his doctors by masking his illness under a ‘vener of near normality’ and that he killed his second victim hours after his social worker and a panel of experts deemed him safe. (Davies, 2005).

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**Practitioner reflection on this coverage** - Do they really think we would just allow a dangerous person to walk around without supervision? This hurts! The fact that he was able to fool us is one thing but then to be criticized for doing what we thought was right is another thing completely. We attempt to provide the least restrictive therapeutic environment for someone who is ill, having made a fair assessment of that individual’s mental state. It is a really difficult job to assess someone who masks symptoms. Do they think we can read people’s minds, or have a magic diagnostic machine.

*Theme 2: Attempting to make a balanced decision.*

Mental patient Peter Bryan ... chopped up Bryan Cherry hours after being let out of hospital by doctors who said he was HARMLESS, a court heard yesterday. (Brough, 2005 - emphasis in original).

Described by a psychiatrist as probably the most dangerous man he had ever assessed, Peter Bryan was let out of high-security detention to fulfil the violent fantasies that swirled in his mind. (Frean & Peek, 2005).

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**Practitioner reflection on this coverage** - This is desperate. One of us feels like all the work he had undertaken in the name of care was for nothing. A locked ward system and a restrictive environment are already imposed upon patients. Perhaps we should abandon all pretence of care, and for the safety of the public lock ‘the mad’ away and throw away the key. We have to make decisions on balance; that balance cannot always be maintained, it potentially tips one way or the other.

*Theme 3: Perceived effects on others.*

Horror turned to anger for the families of the victim and another man that Bryan went on to kill while waiting for his trial, when it was discovered that the cannibal had been released from a high security hospital where he was sentenced for battering a woman to death.

(Bennetto, 2005).

Police officers were horrified to discover Peter Bryan calmly frying human brains on a stove with the dismembered body of his victim at his feet.

(Frean & Peek, 2005).

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**Practitioner reflection on this coverage** – These lines make it clear who the victims are, but not in our minds. No one asks about how the staff that worked with him felt. Not knowing his level of dangerousness, the fact that they may have disclosed something about themselves or family; and so be worried and horrified, about him coming for them or their family. Other opening lines paint these staff as the villains. Additionally others with mental health problems may fear they will be viewed in the same way, as inherently dangerous, just waiting for that fuse to be lit ... some may even believe this to be true.

*Theme 4: Reinforcing the stereotypes.*

A British Hannibal Lecter style killer ate a victim's brain after frying it in butter, a jury heard yesterday. Peter Bryan – dubbed the Cannibal by police – was freed to kill despite being detained 'indefinitely' after a previous murder.  
(Anonymous, 2005).

A cannibal killer fried and ate the brain of one of his three victims and said: 'I enjoyed it. It was really nice.' ..... The paranoid schizophrenic, described by a psychiatrist as the most dangerous man he had ever seen, told horrified police: I ate his brain with butter. I'd have done someone else if you hadn't come along. I wanted their souls.  
(Brough, 2005).

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**Practitioner reflection on this coverage** - Such statements negate all the time and effort that has gone in to trying to normalize mental illness. The image of straight jackets and a leather mask and the obvious; the licking of lips and eating body parts with a nice Chianti – a la 'Silence of the Lambs'. Maybe we should go back to the Victorian days and Bethlem; re-introduce some old treatments: cold showers, public viewings; a penny admittance two if you want a stick to poke them with.

***Results: Initial Practitioner Reflections #2 (Secondary Reflections)***

We read and re-read each form of coverage of the Peter Bryan case: the tabloid ('popular' newspaper) coverage of the final day of the court case, the broadsheet ('serious' newspaper) coverage of the final day of the court case, and the report of the Independent Inquiry. Summary overviews of each form of coverage were produced by author 1 and reflections on these overviews provided by author 2 (an experienced mental health practitioner). The summary overviews and practitioner reflections are provided below.

Where quotes are used in this section without attribution, these phrases were used by a number of the papers – reporting on what was said in the trial.

*An overview of tabloid coverage.*

Peter Bryan was an extremely dangerous man, who should never have been free to carry out the crimes committed. His mental health condition was mismanaged a number of times, so that more than once he was able to inflict horrific attacks on people – that is, the danger that he posed to himself and others was underestimated or missed completely on more than one occasion.

Different elements of the mental health system all made mistakes, tribunals releasing him from a secure unit; and assessments made which enabled him to move into less secure settings. These decisions were even made hours before some of his attacks on people. He was clearly mad, in the lay sense of the term, openly talking about eating or wanting to eat his victims and potential victims – suggesting that this would give him the powers of his victims. He also stated that it was normal to eat his prey – talking about attacking the weakest people, considering them to be lowest in the food chain. Again and again it is reported that the system ‘had manifestly failed to protect the public’.

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**Practitioner reflection on this coverage** - this left me with a feeling of ‘we’ve failed’. The staff, not me! How could they not have known he was ill or address the fact that they were exposing vulnerable people to someone so ‘dangerous’? It really angers me that there was no quality control of the catalogue of mistakes. If I was working with him, I feel I would have fought ‘tooth and nail’ to keep him in hospital and ensure treatment packages were designed and followed through. Staff like this create problems for everyone. They will create work for me by generating layers of bureaucracy that get in the way of care.

It leaves me asking ‘who was responsible and what has happened to them?’ I cannot personally understand why he was let out. I know colleagues who are ‘chancers’; they are often good team members, but they could be taking chances like this. I am sure they are not as bad as this, but I don’t really know! This in some ways poses a dilemma for me. What to do next or just put up with it. But I would be culpable for any mistakes, if I had consciously avoided the issue. It makes me feel like I need to watch others’ practice as well as my own. I am left with a trust dilemma. I know people I work with, like and relate to socially, but they could affect my work. I suppose I feel a little tarnished as a professional and not so proud; none of this could have happened without anyone not knowing.

*An overview of broadsheet coverage.*

Peter Bryan was a man whose mental health status was misjudged, allowing him the freedom to kill even though still under the care of health and social services. The question is whether he was failed by ‘the system’, fooled ‘the system’, or whether his behaviour was just too unpredictable to allow for an accurate assessment of his likelihood to be a danger to the public.

It is clear that insufficient caution was shown by those responsible for his care, and he was given the freedom to carry out acts of horrific violence (including mutilation and cannibalism). It would also seem clear that he was able to appear calm and settled, even hours before an attack as the phrase a ‘veneer of near normality’ appeared in one report. However, a comment that is repeated across nearly all, if not all, reports is that one doctor considered Bryan to be (probably) the most dangerous man he had assessed. This assessment indicates the paradox of this case – ultimately as the prosecuting barrister’s summing up stated ‘the role of experts in the determination of whether this man would no longer present a danger to the public has demonstrably failed’. It is clear that this was not a single failure though – an ‘array of mental health experts’ having been involved. Relatives of Bryan and of his victims are reported as blaming the mental health care system and pressure groups reported as being increasingly worried about the threat those with mental health conditions pose to the public. Thus, Peter Bryan is seen as just one example of the

failure of treatment of violent offenders with mental health care problems, although it is also reported that the mental health care trust described the case as highly unusual.

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**Practitioner reflection on this coverage** - reading this summary of material I was familiar with, was quite chastening. To me it reflects the difficulty of the job of assessing someone but that we did get it wrong. This in some way heightens personal anxiety about the people you both work alongside and with. It reaffirms the unpredictability of people and if you are not careful you start, as I have, 'looking over your shoulder' all the time. This indirectly raises questions about my decision-making and that of others.

I am unsure if the fact that he could 'fool' a system that was working *well* could effectively happen. Yet with all the demands and stresses that working within targets places us under, we could all make mistakes. It does irk though, that non-professionals can criticize in respect to this case and cast doubt over our abilities in a seemingly un-informed way. So I find myself being defensive towards my peers, even without any real evidence.

Even though I feel defensive towards criticism and in some way internalize this, as though I am as much to blame (the lack of a named culprit, suggests blame on everyone) I still feel deeply angry that this was allowed to happen. I feel that the family was right in 'blaming the mental health care' system in this case, given what happened. At the same time, maybe because of this blame my own practice will be more closely scrutinized; and if it is anything like in the past I will end up doing more and more extra paperwork. Paperwork that keeps me away from face to face contact, consequently reducing my chance to assess people in more detail. Thus I feel a certain resentment at this display of blame, and that the diffusion of this blame - resulting from the practice of these 'professionals' working within this system - will make things 'worse' for myself and other practitioners like me. Nothing positive seems to be said about what we do, only bad things.

*An overview of coverage by the 'official report'.*

Peter Bryan is clearly a dangerous man – this is evident from the murders he has committed, one of which was described in the report of an independent inquiry to be ‘particularly horrific and bizarre’ (Mischon et al., 2009 p9).

It is the relatively hidden nature of this dangerousness, however, that poses the real problem – his ability to ‘appear relatively normal whilst remaining capable of extreme and unpredictable violence’ (Mischon et al., 2009 p10). He also appears to have developed the ability to control situations when in secure care, through deception or manipulation.

Whether his behaviour was purposefully controlled or not, numerous witnesses that saw him in the hours immediately before and after the ‘horrific and bizarre’ murder, reported that he appeared normal, was displaying no signs of mental disorder and was calm and no different than other times. Thus it would appear that Peter Bryan was a very difficult patient to assess and to manage appropriately – in part because of the atypical and complicated nature of his mental disorder, which consequently presented in an unusual way. To be successfully managed he required specialized highly structured environments which resulted in a high degree of certainty. Unfortunately the success (or apparent success) of such measures, in the past, resulted in his release to less appropriate environments. Once released to less secure environments he was nonetheless able to mask deterioration and manipulate staff – particularly those with less experience of dealing with such complex clients, especially if they had little knowledge of him and his history. With hindsight much of this became apparent. However, without this hindsight, he and others became victims of his dangerousness.

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**Practitioner reflection on this coverage** - this worries me, this is an area that I have worked in. I could have easily ended up working with this man who appeared ‘normal’ yet went on to ‘kill’. I am finding myself fumbling around for something tangible to hold on to, to give me comfort but can only see the ‘runaway train’. I feel a sense of impotence which

is quite disturbing' given the staff were unwittingly controlled. This feeling is reinforced by my belief that whatever happened would have happened anyway; he called all the shots.

Anxiety is raised in me that less experienced (vulnerable) staff, were left to deal with him, especially given his 'manipulative' past. As a clinical supervisor of such staff, it left me questioning where all the supervision was and who would allocate someone like this to an inexperienced member of staff? It seems to smack of money saving, employing junior staff to replace senior ones and treating them as though they are the same; staffing levels being maintained, but only in a numerical sense.

It leaves me uneasy about the amount of control I have over what I do and how I will practice. Ultimately I question what could have been done and could I have acted any differently. I can see that I am more edgy in respect to risk and whilst reading the narrative I experienced odd yet related thoughts to risk assessment questions and tactics that may have been or may not have been used. It left me feeling that the outcome was inevitable with this person in this situation when he was inappropriately managed; but that I would have managed it differently (although this could be me, trying to convince myself that it couldn't happen to me). It also highlighted fears in me that say you will only be measured on what you do wrong.

***Results: Final Practitioner Reflections #3 (Tertiary Reflections)***

Re-reading our previous reflections we were struck by how defensive of mental health practitioners our reactions to the opening lines of the newspaper reports are (primary reflections). The reflections stress the difficulties in dealing with clients such as Peter Bryan and anxiety that the threat will potentially lead to risk-averse (perhaps overly risk-averse) practice.

In contrast, the secondary reflections are not as defensive. In responding to tabloid coverage defensiveness towards practitioners turns to an attempt to apportion blame. Such

attempts to apportion blame were driven by an element of professional pride and the potential implications that such media coverage has for practice in general. Reflections on broadsheet coverage are more ambiguous; there is still a strong sense of blame that this case was mismanaged, but tinged by a sense of understanding of the difficulties in dealing with such a case. The implications for personal practice still emerge as a concern. This ambiguity is continued when reflection turns to the Independent Inquiry Report. The sense of blame is now muted, but concern remains that inexperienced practitioners were left to manage this case; and for the implications of the case for others' practice.

The main question that these reflections pose is: 'Would an experienced team of workers, working to best practice have dealt with Peter Bryan in a more appropriate way, with better outcomes for all concerned'? At the time that the newspaper reports reviewed were produced, a raft of related documents was available that would indicate that evidence-based practice, operating within a framework of values-based practice, both could and would improve outcomes (Morgan, 2000; National Institute for Mental Health in England, Sainsbury Centre For Mental Health; National Health Service University, 2004; The Sainsbury Centre for Mental Health, 2001; Woodbridge & Fulford, 2004). Such documents suggested that the capability of mental health care practitioners is developed as core knowledge and skills are applied in practice, and subsequently reflected upon. Such knowledge and skills include the implementation of evidence-based interventions such as the use of appropriate assessment tools. Reviews of such tools and their use in practice (see for example: Doyle & Dolan, 2002; Kettles, 2004; Towl, 2005) identify that there has been a movement away from the use of clinical judgment in assessing risk. This approach was initially actuarial (reliant on the predictive power of assessment tools to calculate levels of risk), but more recently a structured clinical judgment approach that 'bridges the gap between empirical science and clinical practice' has been proposed (Kettles, 2004 p488; see also Webster, Hague & Hucker, 2013).

Thus, there is the suggestion, in such literature, that an experienced practitioner is able to utilize and articulate the role of clinical experience and expertise in applying the evidence base relating to risk assessment. It is this ability to undertake such mediation that separates



the experienced practitioner from the informed novice. Thus, this capability alongside others (in particular effective communication within a multi-disciplinary team) could well be considered to mean that an experienced team of workers, working to best practice, would have dealt with Peter Bryan in a more appropriate way, with better outcomes for all concerned. A word of caution should be added here though, as Szmukler (2000) argues that, given their relative rarity, such events are by their very nature unpredictable.

A second question that arises is whether adverse media coverage such as that of the Peter Bryan trial may result in a mental health practitioner altering their practice in a risk averse manner, resulting in them acting in a way that might reduce the quality of care provided.

The reactions and reflections (primary and secondary) presented above suggest that in the case of one experienced practitioner this may well be the case. But these reactions were immediate reactions / initial impressions of the material, followed by a more considered overview based on more detailed reading of the material itself, and reflection on how it related to our own experience and tacit knowledge. Thus there was still a need to attempt to contextualize this reflection in terms of appropriate evidence as provided by the literature (drawn from a limited, favoured, source reflecting the situation of the ‘typical’ practitioner).

Initially the literature we had to hand, as interested practitioners, dealt with debates about the use of risk assessment tools (Doyle & Dolan, 2002; Kettles, 2004; Towl, 2005); but we searched further and came across other material – moving from mainstream psychiatric and mental health literature, to that relating to risk and mental health more generally. In so doing we found Godin (2004); Godin (2006a) an edited text containing Alaszewski (2006) and Godin (2006b). This reading led us to Castel (1991) and Rose (1998); literature that was added to the raft of reports, guidelines and frameworks indicated above.

Turning to Alaszewski (2006) two premises provided some verification of our own

practitioner reflection:

... a series of high profile inquiries in mental health services have highlighted public concerns and the need to identify and manage dangerous individuals ...  
 ... Contemporary health and welfare agencies ..... need to identify risk so that they can avoid investigation and blame.  
 (Alaszewski, 2006, p.30-31).

Godin (2004) acknowledged these premises as influential in the development of 'risk thinking'; however, he later argued its roots were in a broader move towards greater governmentality (Godin 2006b), citing Castel (1991) who argued that modern medicine in general had drifted to:

... a new mode of surveillance: that of systematic predetection. This is a form of surveillance, in the sense that the intended objective is that of anticipating and preventing the emergence of some undesirable event: illness, abnormality, deviant behavior, etc.  
 (Castel, 1991, p.288).

Thus, perhaps media coverage of mental health is not as influential as our own reflections had suggested. However, Godin also noted that,

Mental health care workers are ... frustrated with a system that requires them to regard their clients as objects of risk, crowding out the care for the well-being of individuals. They become frustrated with feeding data into the system and its disapproval of therapeutic risk taking. (Godin, 2006b, p.77).

Thus, whatever the reason for the rise of formalized risk assessment, some of the issues for the mental health practitioner stay the same, and we found ourselves in general agreement with Godin's statement that

... mental health care workers are allowed discretion in how, amongst other things, they assess and manage risk. They could use this discretion to broaden the concept of risk to incorporate what might be seen as patients' needs and wants, to redefine them as the risks that would, as such, merit attention ..... In doing so, mental health care workers might be able to change risk thinking into a discourse that includes the things that service users are concerned about. Through such redirection of risk thinking nurses might be able to reassert their professional mission of caring.  
(Godin, 2006b, p.78).

Considering these texts, reinforced the frustration we felt and had expressed in earlier reflections on media coverage of the Peter Bryan trial; and to some extent we had come full circle in our view that perhaps media coverage led to the use of conservative risk management or a risk averse approach to dealing with all clients without discretion. So where did this leave us?

### **Final Reflections Or Summing Up**

As in criminal trials, like that of Peter Bryan, bricolage often presents evidence and lets the jury come to their own conclusions. Wibberley (2012 p.2) stated in a number of examples of bricolage 'ultimately the account is left to speak for itself, so that the reader can make of it what they will'. We feel, however, in this case, that as in trials, some summing up is warranted.

The worry that we initially had was that all this reflection had left us no further forward in our thinking about: a) the media's impact on practitioners - in terms of them perhaps adopting more risk averse practice than perhaps was in the best interests of their clients, and b) how this may be avoided, if appropriate, through reflective practice. But then we considered what normally happened after independent inquiries into incidents such as the one we were reflecting on – that a spokesperson for the 'responsible' organization would be

sent out to the press with a statement that suggested that the report would be read carefully and any lessons that needed to be learnt by the organization, would be learnt and changes implemented. The question remains though, of ‘how others might learn from such incidents?’

We stated earlier that an experienced practitioner is able to utilize and articulate the role of clinical experience and expertise in applying the evidence base relating to risk assessment. It is this ability to undertake such mediation that separates the experienced practitioner from the informed novice. The experienced practitioner in our team (Author 2), despite our initial worries, did feel that reflection on the Peter Bryan case had helped him to consolidate his position in relation to the assessment of risk posed by those with a mental health problem. Thus it would also seem reasonable to suggest that a relatively novice practitioner could benefit from reflection on this and other cases – learning, at least partially, ‘the lessons’ from vicarious experience. Those that have more experience may learn most from such reflection (being able to reflect on their own experiences when reflecting on the case); however, both experienced and novice practitioners would hopefully become more informed practitioners from their reflections.

This does seem a pertinent way to think of the use of such an incident, as occurred with Peter Bryan, as in this case it was the relative inexperience of the practitioners that led, at least in part, to inappropriate practice being followed. Thus we would recommend the use of reflection on such cases both in clinical supervision and formal education so that such learning can be embedded in the practice of mental health practitioners. Without such reflection appreciation of the influence that social factors (such as media reporting) play on the actions of the general public and on professionals involved in the care of the mentally ill may be downplayed. If stories like the Peter Bryan case are not discussed and unpacked then the potential influence of media reports relating to risk may go unnoticed by practitioners and their practice be unwittingly deflected from its evidence based path.

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