DEVELOPING A RECOVERY ETHOS FOR PSYCHIATRIC SERVICES IN NEW ZEALAND

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ABSTRACT

This thesis is about developing a recovery ethos for psychiatric services in New Zealand. The argument of the thesis is that currently a procedural ethos is dominant in psychiatric services in New Zealand, based on eclectic ways of facilitating recovery. Recovery from mental illness, is based on the criteria of symptom reduction and functioning and can be further refined to have a client and professional perspective. Rather than using an eclectic approach to facilitating recovery the thesis argues for a pluralistic approach, where the virtues, the relationship with professionals, client narrative and the psychiatric community become central to decision making, rather than principle based procedures.

The thesis is an argued, applied philosophical thesis in terms of methodology. The scope of the thesis is psychiatric services and the focus is broadly ethical decision making. There are three main divisions to the thesis. Part 1 is concerned with clarification of the main terms used in the thesis. This involves exploring the historical background to the concept of recovery, clarifying the concept of recovery itself and providing an argument for giving greater prominence to the term mental illness over the term mental disorder. Part 2 identifies the main problem of the thesis, namely the procedural ethos, and the problems it is causing clients suffering from mental illness in facilitating their recovery. Part 3 shows what is involved in developing a recovery ethos for psychiatric services in New Zealand.

PREFACE

The following thesis was written during the period 2004 - 2006 while a Philosophy Ph.D student at the University of Waikato. The central ideas of the thesis have been ones that have germinated over the past decade in my clinical work as a psychiatric nurse. This is not a thesis that is focused on psychiatric nursing however, but on psychiatric services. While this work has been written with much passion I believe that does not preclude the work also offering a rational and coherent insight into psychiatric services within New Zealand.

ACKNOWLEDGEMENTS

I have many people to thank for this thesis, more people than I can possibly acknowledge. There are some people, however, who I must acknowledge.

Firstly my wife, Urmila, for her support and encouragement over the past few years; my Supervisors from the University of Waikato: Dr David Lumsden and Dr Liezl van Zyl and latterly Dr Doug Boer; also Professor Grant Gillett from Otago University where I initially enrolled.

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INTRODUCTION

Let me start with a personal reminiscence that crystallises the fundamental problem with which this thesis deals.

The reminiscence relates to a planning session within a psychiatric service[1] to deliver 'recovery focused services'. Present were managers, many different clinicians from various professional disciplines, and client and family representatives. The only thing these representatives (including myself) could agree on was that 'recovery focused services' was a good idea but what that actually meant sparked a range of views, some of which were quite incompatible. In order to achieve consensus, the planning session agreed to follow a minimal set of procedures for reaching decisions in the future. In other words, while the planning meeting could agree on a notional form of words for the ethos of the service, the substantive content of what those words meant was harder to find agreement on. Hence the need to resort to procedures.

This reminiscence highlights an important problem for modern psychiatric services; namely that of finding an ethos that is focused upon the clients they serve but also being able to talk meaningfully to professionals and the clients' families without resorting to procedures. Modern psychiatric services comprise many competing views on the nature of mental disorder and how it should be treated. These differences are most particularly marked between client and professional perspectives. There are also many different psychiatric professionals with their own history and traditions. In articulating any common views or statements about psychiatric services there is, therefore, the need to go beyond a notional set of words – which can sometimes be nothing but empty mantras – to an underlying agreement about substantive content. Agreement about content should not be seen as meaning consensus. Consensus is essentially an attempt to find a position that everyone can agree with at whatever cost. Consensus is one of the dragons that I want to slay in this thesis.

The need to achieve consensus, I believe, has led psychiatric services into adopting a procedural ethos as its current *de facto* philosophy. This procedural ethos,

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[1] Throughout this thesis I use the term psychiatric services to refer to publicly funded services in New Zealand providing services to those clients with serious mental illness. When I refer to 'other mental health services' I include non-governmental organisations, private services and primary services which are mostly targeted at people with mild to moderate mental health problems. Sometimes the term 'mental health services' is used by other writers to refer to psychiatric services.

it is thought, is a way of achieving consensus in the face of professionals holding apparently irreconcilable beliefs about the nature of mental disorder and how it should be treated. As I will show in this thesis, however, consensus comes at a very high price. That price is that procedures become the main way in which decisions are made in psychiatric services.

The aim of this thesis is two-fold. The first is to criticise the procedural ethos, which I will argue currently pervades psychiatric services. The second is to propose and defend an alternative to the procedural ethos, namely what I call a 'recovery ethos'. As a consequence, this thesis is trying to answer two questions. Firstly; why is the procedural ethos a problem for achieving recovery from mental illness in psychiatric services? Secondly; how do we replace this procedural ethos with a recovery ethos?

The first question is important because, at its most crucial, the idea of an ethos *is* important. An ethos is the spirit of a community, its motivating purpose and rationale. The ethos of psychiatric services is of great importance in terms of assisting clients who have a mental illness but that ethos receives (and has received) little attention from either psychiatric professionals or philosophers. Historically, the ethos of psychiatric services has had a strong emphasis upon the professional ethos of psychiatry.

The various professional groups within psychiatric services all have a particular professional ethos. Psychiatry has been the dominant professional group within psychiatric services and therefore, to many people the professional ethos of psychiatry has been seen as the ethos of psychiatric services[2]. During the long period from the nineteenth century into modern times when expertise was venerated, this professional ethos of psychiatry did essentially become the ethos of psychiatric services. This professional ethos of psychiatry was essentially about showing how psychiatry (and hence psychiatric services) was just another branch of medicine, like cardiology or endocrinology. Psychiatrists are trained as medical doctors so it is reasonable that their professional ethos should reflect this – the problem is in extending this ethos beyond psychiatry to engage with other disciplines, and clients and their families. Other medical specialties and psychiatry have many commonalities; these other medical specialties, for example cardiology and

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[2] The dominance of psychiatry is reflected in the type of clinical procedures which are dominant in psychiatric services, particularly the psychiatric classification systems.

endocrinology, tend to result in medicine providing the dominant professional ethos within those specialities. There is, however, a fundamental distinction between psychiatry and other areas of medicine which makes the professional ethos of psychiatry inappropriate for psychiatric services in general. Psychiatry may involve diagnosis like medicine, but that diagnosis is based on descriptive psychopathology rather than an aetiological classification system and, unlike medical diagnosis, there is no place for pathology biopsies in confirmation of diagnosis. In other words, there is much more to psychiatric services than diagnosis and treatment understood in narrowly medical ways. The professional ethos of psychiatry is simply not inclusive enough of the various other professional groups and clients to warrant becoming the ethos of psychiatric services.

Nursing has become the largest professional group in terms of numbers within psychiatric services. Nursing within psychiatric services has, however, never had one articulated ethos but a consensus has developed around the centrality of the therapeutic relationship between the nurse and the client. This therapeutic relationship is seen as fundamental to all care and treatment and needs to be genuine, meaningful and imbued with integrity and honesty. There are, however, problems with adopting such a 'thin' ethos based on the therapeutic relationship as the ethos of psychiatric services. One problem is that it tends to emphasise interpersonal interactions and hence a social model of care; whereas biological and psychological approaches are also important and while such approaches might use a therapeutic relationship they would not necessarily be based on them. The therapeutic relationship simply does not carry enough content to stand by itself as the ethos of psychiatric services. It does, however, have the advantage of being based on something that all professional disciplines and clients can relate to[3].

The ethos of other professional groups, such as that for psychology, social work and psychotherapy, also tend to be insufficiently inclusive of other professional groups and clients to become the ethos of psychiatric services.

This leaves the task of finding an ethos of psychiatric services that is inclusive of all professional groups, clients and their families. There has been an attempt to make recovery the ethos of psychiatric services, but with very limited success. This notion of recovery articulated for millennia by carers as disparate as

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[3] As we will see later, the relationship between clients and professionals while not sufficient to be an ethos in itself is nevertheless part of the recovery ethos.

Hippocrates and Galen has become the *formally* identified ethos of psychiatric services in the past decade. Prior to this *formal* recognition, recovery has historically always been part of psychiatric and other health services but often in an unrecognised or understated way. The Mental Health Commission in New Zealand articulated recovery as the ethos of psychiatric services in 1998 and this was reiterated in the Second National Mental Health Plan released by the Ministry of Health (2005). While recovery has become officially endorsed as the ethos of psychiatric services, this appears, however, more of a wish and a hope than a reality.[4]

While recovery has formally been recognised as the ethos of psychiatric services, in reality I would maintain it is the procedural ethos that is the real ethos and recovery has simply been 'proceduralised.[5]' Moving the ethos from procedures to recovery will take more than simply wishing it so.

There are advantages in choosing recovery as the ethos of psychiatric services. Its main advantage is that it makes the client a central focus. Historically there has been a focus upon the expertise of the psychiatric professional as the ethos of psychiatric services and with it a focus, not upon the client, but upon those psychiatric professionals.

While recovery has been presented as the ethos of psychiatric services, as I will show in this thesis, there are a number of different conceptions of recovery and different ways of fostering recovery. The current 'recovery approach' introduced by the Mental Health Commission (1998) and forming the basis of the current *formal* acceptance of recovery has a very client-centred conception which depends upon clients deciding for themselves whether they are recovering and emphasising the client's responsibility for fostering their own recovery. While this approach has gained traction, it has not been able to become sufficiently inclusive of all the professional groups involved in psychiatric services to become the real ethos of psychiatric services.

The particular 'recovery approach' conception of recovery which has become dominant at the moment is only one conception of recovery. Recovery is a

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[4] The Ministry of Health's *Te Kokiri* (2006) contains the following sentence in its glossary in connection with recovery "A challenge faced by both the mental health and addiction sectors is the ongoing development of the concept and language of recovery" (p.79). As this quote indicates, there is a recognition that more work needs to be done on clarifying and exploring the concept of recovery. This thesis is an attempt to do that.

[5] As I will show in a later chapter. the idea that recovery has been medicalised rather than proceduralised within psychiatric services is mistaken. Psychiatry itself has come to rely on procedures.

rich and complicated concept. Historically, psychiatric professionals determined whether clients were recovering. During the long period when expertise was in the ascendancy within psychiatric services, this professionally determined understanding of recovery was seen as the only valid understanding of recovery, irrespective of whether those approaches were biological or psychological in nature. Within psychiatric services, as opposed to most of the other mental health services (such as non-governmental organisations, primary services and private care), there remains a strong attachment to professionally determined approaches to understanding recovery. Within these other mental health services, the client-determined approaches to recovery have become more dominant. There has, therefore, been tension and disagreement between psychiatric services with their professionally determined emphasis on recovery and other mental health services where client-determined approaches have become more dominant. Within psychiatric services this tension is also sometimes apparent. There has also been a strong emphasis within the recovery approach on clients taking responsibility for fostering their own recovery. The role of professionals is often seen in ambiguous ways in terms of fostering recovery within this approach, an ambiguity dealt with by using consensus-building techniques based on procedures.

The procedural ethos has accepted the formal language of the recovery approach but has embraced an approach to fostering recovery based on a form of eclecticism These procedures provide a mechanism for building consensus and they tend to take the form of a reliance upon guidelines, protocols and policy.

This thesis is essentially attempting to present a philosophical basis for a recovery ethos[6] in psychiatric services. Recovery is a field of study which has received considerable attention from clinical perspectives and from consumer groups but has received little attention from philosophers or ethicists, which is unfortunate since understanding the notion of recovery is a requirement for the development of an adequate recovery ethos. While there are competing views on what recovery means there will continue to be an emphasis upon eclecticism as a way of achieving consensus. This is partly why the procedural ethos within psychiatric services has persisted. A major motivator for this study is to fill that philosophical vacuum with an

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[6] The recovery ethos should be seen as a broad *de facto* philosophy of psychiatric services. While there are specific issues involved in recovering from particular illnesses that is not the focus here. In other

attempt to provide a cogent, logical analysis of what a recovery ethos might look like. As things stand it could be argued that the Mental Health Commission's (1998) 'recovery approach' will fail, since it represents only one approach to recovery and one insufficiently inclusive of the various psychiatric professionals involved in providing psychiatric services.

Part of my attempt to answer the second question which this thesis addresses; How do we replace a procedural ethos with a recovery ethos? concerns the importance of understanding responsibility. In developing a recovery ethos we need to ask ourselves: When does responsibility for mental health care move from the professional to the client and vice versa? Traditionally, the expert clinician had the answers and the client was a passive recipient of care who had little or no responsibility for their own recovery. Alternatively, but associated with this, are recovering clients who relapse and need additional assistance and who need to pass some responsibility back to the various psychiatric professionals. The purely client-determined understanding of recovery, in which the client is largely responsible for fostering their own recovery, has no difficulties with the notion that the client can assume increasing responsibility for their own health. However, such an approach tends to have difficulty when the psychiatric professional needs to assume increased levels of responsibility for the client's health. The various professionally determined ways of understanding recovery and fostering recovery have no difficulty with the notion that psychiatric professionals can assume increasing responsibility for a client's health but they often have more difficulty letting go of some of that responsibility and assisting clients to find their own way. Any professionally determined understanding of recovery and professionally focused way of fostering recovery which is not balanced with a client-focused way of determining and fostering recovery will find it difficult to account for the client's recovery journey in total. This is the basis for my argument for a pluralistic approach to fostering recovery in which professionally determined and client-determined approaches are respected, but not equally, for each phase of the client's journey towards health. I will argue that this pluralistic approach to fostering recovery cannot rest upon procedures which, in turn, are based on principles as the mechanism for determining when one or another approach to recovery should be used, but needs to be based on client and professional

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words the recovery ethos applies to all mental illnesses, with self awareness the only complication, since (as I will show in Part 3) a certain level of self awareness is needed to develop virtues.

virtues and client narratives with its basis in a psychiatric community. This pluralistic approach to fostering recovery revels in difference and almost rejoices in differing conceptions of recovery and does not attempt to generate some consensus understanding. Unlike eclectic approaches based on procedures, it does not try to smooth over differences but honestly acknowledges them and then tries to resolve any differences by determining which approach is best at the specific moment, drawing upon the particular virtues of client or professional. For clients to recover, amongst many other virtues, they need to trust psychiatric professionals and be able to collaborate with them. In addition to technical virtues and many other virtues, professionals need the virtue of clinical wisdom to know when to withdraw and when to become more involved in a client's care. The nature of the collaborative relationship between professionals and clients is one way these virtues can be developed. In addition to these virtues, clients need to find some level of meaning in their illness experience so that they can start to develop a recovery narrative as part of their journey from illness to health. Finally, in order to implement a pluralistic approach to fostering recovery, I argue for a psychiatric community so that there can be some agreement about the ends being pursued by psychiatric services and other mental health services, and hence the kind of decisions which need to be made at each stage of the client's recovery about which approaches should be dominant.

There are, as a consequence, four main tasks associated with this thesis. Firstly, there is considerable confusion about what recovery means in the context of mental illness, so the task in Part 1 will be to clarify some of this background. Secondly, there is the explanation of recovery by either a professionally determined or client-determined approach and the task is to show (see Chapter 2) that recovery should be seen as a broader concept than either of these two versions seen in isolation. Thirdly, Part 2 will argue that the ethos of psychiatric services is currently a procedural ethos based on an eclectic approach to fostering recovery and the task is to show the weakness in this procedural ethos. Finally, in terms of developing a recovery ethos based upon a pluralistic approach to facilitating recovery, the task is the need to re-engage with an older virtue and narrative tradition set within a psychiatric community as will be shown in Part 3.

The scope of this thesis is narrowly psychiatric services in New Zealand rather than the broader scope of psychiatric and other mental health services in New Zealand. However to develop a recovery ethos, psychiatric services need to share the

same ethos with other mental health services. This is in contrast with the procedural ethos, where psychiatric and other mental health services do not share the same procedural ethos. While this thesis could have been written with the broader scope of psychiatric and other mental health services in mind, the scope has been narrowed to psychiatric services since this is where the most impact will be had from developing the recovery ethos. The reason that most impact will be experienced from developing a recovery ethos within psychiatric services is that this is where most clients with serious mental illness are currently receiving services. Additionally other mental health services, particularly non-governmental organisations, comprise a diverse group, and it would take more space than was available in this thesis to address the application of the recovery ethos to all those various services.

The focus of this thesis is broadly ethical. However the reason for this focus is not because recovery only involves ethical decisions, since recovery involves decisions in all the various health domains[7]. However, decisions made about which health domain to apply, while possibly clinical decisions in themselves, are based on ethical assumptions. Those ethical assumptions are determined by the ethos within which people receive services or work.

This is an argued thesis in terms of methodology and that argument is laid out in three parts comprising a number of chapters made up of a number of sections. The methodology of this thesis is in contrast to a more empirically focused thesis. This thesis will be developing an applied philosophical argument which, while at times it will rely on empirical studies for support, is not itself an empirical study.

Part 1 will be divided into three chapters and is broadly concerned with clarification of the main terms and concepts involved in the study. Chapter 1 will provide an historical introduction to the notion of recovery from mental illness, indicating that 'recovery' has had changing meanings over the past two thousand years in the western tradition, almost all in the professionally determined tradition of recovery. Only recently has the explicit use of recovery as a client-determined conception started to be discussed as a possible ethos underpinning psychiatric services. Chapter 2 will clarify the concept of recovery itself and indicate that the concept is best understood by distinguishing between professional and client

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[7] Health domain refers, respectively, to biological, psychological and social professional approaches. Culture and spirituality are also sometimes considered as health domains. However in this thesis, it should be seen as referring to biological, psychological and social approaches.

perspectives on the nature of mental improvement. Chapter 3 will provide clarification of the conceptual foundations of the thesis in the sense of showing which understandings of mental disorder, mental illness and mental health will be used in the thesis that are consistent with a pluralistic approach to fostering recovery.

Part 2, Chapters 4 and 5, will be concerned with the problem of a procedural ethos in psychiatric services and how that ethos gets in the way of recovery. Chapter 4 will background and analyse the theoretical understanding of a procedural ethos, showing how all-pervasive it has become and the way in which an eclectic approach to fostering recovery has become dominant. This procedural ethos is essentially an attempt to generate consensus in an area dogged by disagreements. Chapter 5 will detail the problems with that procedural ethos, based on a form of eclecticism, towards fostering recovery. It is interesting to note that, while bioethics and the philosophy of medicine and nursing have concerned themselves with investigations of competency, autonomy, surrogate decision-making and the like, recovery has received little attention in philosophical writing. This is curious given the centrality of recovery for the whole venture of psychiatric treatment and care. The focus in these disciplines, particularly bioethics, has been on procedural attempts to provide consensus. Indeed the paradigm of consensus in bioethical discourse is the institutional ethics committee, which has much to do with procedures but arguably little to do with either ethics or bioethics. There has also been little discussion of the nature of an ethos in healthcare, which is also curious given that an ethos can be seen to contain current ethical concerns but also to go much wider and indicate the prevailing spirit of a community. Chapter 5 will show, from a practical perspective, how the procedural ethos makes recovery harder rather than easier.

Part 3 is broadly concerned with how a recovery ethos based on a pluralistic approach to fostering recovery could replace a procedural ethos based on an eclectic approach to fostering recovery. Essentially, Part 3 indicates how a recovery ethos could be realised. There are four chapters to this part of the thesis which detail and argue for aspects of the recovery ethos. Chapter 6 describes and analyses how the virtues and development of character are a foundational aspect of the recovery ethos, indicating the character virtues which clients and professionals would need in order to assist a client to recover in a pluralistic way. It emphasises the central role of psychiatric professionals in terms of their role in teaching clients the virtues necessary to recover. Chapter 7 then provides some notion of the type of client-professional

relationship that is likely to assist in fostering recovery. Chapter 8 provides a further component of the recovery ethos: the need for clients to develop a recovery narrative to assist with their recovery and the identification of the virtues that are activated at particular points in a client's life through the development of that recovery narrative. The final component of the recovery ethos, Chapter 9, is focused on the notion of a psychiatric community that, it will be argued, is a necessary context if we are serious about introducing a recovery ethos. This is because there is no consensus currently within a liberal society, or within psychiatric services, on the human goods that individuals should pursue. Consequently, it is unclear which decisions are needed to determine the approaches that should be dominant at any point in a client's recovery journey. The idea of a psychiatric community for psychiatric and other mental health services addresses the need to achieve some agreement about the purposes and objectives of psychiatric care. It also provides a link back to the idea of an ethos as the spirit of a community. I will argue that in order to have a recovery ethos, some agreement about the nature of recovery and the ends we are aiming at in psychiatric care is necessary.

CHAPTER 1
Historical Background to Recovery

Recovery[1] from mental illness is viewed differently today from the way it has been viewed in the past. In the future, the nature of recovery will almost certainly be viewed differently to the way it is viewed today. This chapter discusses some historical background to the current understanding of the nature of recovery.

The argument in this chapter is threefold. Firstly, Section One will explore our changing notion of recovery from mental illness[2] by considering the history of psychiatric services which has had an alternating biological and psychological understanding of how recovery from mental illness occurs. Almost all of this history has happened within the professionally determined tradition of recovery. These professional approaches have been in the purist tradition until recently, when eclectic approaches have been used. 'Purist' refers to an approach that used one of the professional health domains exclusively, either biological or psychological. 'Eclectic' refers to an approach that uses a combination of professional health domains and client self help approaches. Secondly, Section Two will indicate that 'the recovery approach', which is focused on client based ways of fostering recovery, can be seen as having three phases in its recent development. These three phases have essentially brought together strands from wellness approaches, existential approaches and magical/supernatural approaches while attempting to reject much of the historical approach from psychiatric services, by emphasising a self-determined approach to recovery. Thirdly, Section Three will show how the ethos of psychiatric services has changed through the past few centuries.

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[1] Until I clarify the concept of recovery in the next chapter I will use the word in the loose sense of getting better. However, as will be explained in more detail in Chapter 2, there is a difference between the way we foster recovery and the criteria for determining whether recovery has occurred. Historically this is particularly marked since, for example, during the superstitious ethos the criteria for recovery would have been ' lack of possession by the devil'. As will be seen, historically there have been predominantly two ways of fostering recovery professionally, biological and psychological approaches. Historical ways of fostering recovery are the focus of section one in this chapter.

[2] The term mental illness and mental disorder are not the same. Chapter 3 will further discuss these differences. Suffice to say here that mental illness is the preferred term. The term mental disorder is used when referring explicitly to psychiatric classification.

There is a common way of presenting the history of psychiatric services[3] in which the practice of psychiatry has evolved and thus advanced over time. These books show the current place of scientific psychiatry to have been achieved through new advances in psychiatric research and clinical practice. As a counter to such a progressive perspective, the work of Foucault (1965) can be refreshing. Foucault sees the development of scientific psychiatry as representing ever more sophisticated means of controlling and manipulating the mentally ill. It is perhaps impossible to stand outside the assumptions of one's own time and present a perspective-less view, a view from nowhere, so to speak. This is even more true when looking at the history of recovery from mental illness, since in determining past views on the nature of recovery we inevitably use material from that time with all the assumptions and perspectives of that period. There have been attempts to see the history of psychiatry as an anthropological enterprise with different traditions within various societies and civilisations, for example in the work of Rosen (1968), but such approaches inevitably take a position with regards the underlying pathological processes.

The current procedural ethos provides a powerful way of making sense of issues in psychiatric services. This procedural ethos has been the dominant way of conceiving of issues in psychiatric services for the past two or possibly three decades. Many professionals trained while this ethos was in place, and have known no other service ethos. It has become a feature of modern psychiatric practice. However, it has not arrived from nowhere: the seeds of its birth can be traced back to earlier periods. In tracing this historical development, my purpose is not to provide a comprehensive history but rather one where I am seeking to show that the professionally determined understanding of recovery has alternated between biological and psychological approaches over the centuries. This flip-flopping has resulted in different beliefs concerning how to foster recovery. Additionally, running in parallel with these disorder formulations (whether biological or psychological), there have also been supernatural and magical accounts. These supernatural and magical accounts are particularly important in psychiatric history, as they have been influential. Additional

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[3] There have been a number of important historical works on psychiatric services: for example Ackerknecht (1968) which has a strong clinical focus in its historical sweep; the magisterial work by Alexander and Selesnick (1967) which is particularly useful in identifying historical themes; Jones (1972) who traces the historical development of psychiatric services from the 18th century to the 1970s from a British perspective; and Jones (1983)who has a clinical treatment focus in its short coverage of historical developments. Additionally, more recently, Shorter (1997) provides a useful sociological

to these accounts, there have been increasingly important wellness accounts of mental health. By wellness accounts I refer to approaches which are focused on what is needed for good mental health rather than approaches focused upon treating disorder.

This has given rise to a problem in that professionally determined and client-determined approaches to recovery are unable to achieve a satisfactory consensus. In the modern era, in large part because of the difficulty of achieving consensus (between the various approaches mentioned), we have adopted a procedural understanding. The recovery approach – which I see as falling into three chronological phases – has not yet become a recovery ethos within psychiatric services. We can speculate on the possible reasons for this and I will provide an explanation in later chapters. However, I will broadly argue that the recovery approach uses a narrow understanding of how to foster recovery which can never be inclusive enough of all the various psychiatric professions.

Section One: History of Recovery in Psychiatric Services

Hippocrates (c490-430 BC) was the first figure in the western tradition to attempt to explain all diseases on the basis of natural causes. The Hippocratic writings - known as the corpus Hippocraticum – consists of more than seventy-six treatises on more than fifty subjects. Hippocratic physicians emphasised observation as the basis for symptom identification. So profound has been the Hippocratic influence that even students today learn the tenet that 'it is nature that heals the patient' and the doctor is simply nature's assistant. While students today learn the concept of homeostasis, medicine in Hippocrates time was based on the humoral theory. The humoral or 'classical' theory of disease (that of both Hippocrates and Galen) is the theory of the four humours. In this theory the body consists of four different juices: blood, yellow bile, black bile and phlegm, which correspond to the four elements: air, fire, earth and water. To each humour belong two of the four qualities: hot, moist, dry and cold. One humour predominates in each of the four temperaments: the sanguine, choleric, melancholic and phlegmatic. All diseases are caused by a disturbance in equilibrium of the humours, by the predominance or failure of one of them. Melancholia, for example, is a disease caused by the predominance of the hypothetical black bile. Hippocrates was interested in cases which were seen to have 'failed' and he himself

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account of the history of psychiatry, particularly strong on the 19th century and the rise of psychoanalysis. All these accounts share the progressive, evolutionary perspective.

claimed that up to sixty percent of his difficult cases ended fatally. He introduced numerous supportive therapeutic methods, for example exercise, bathing, dieting and proper hygiene. In terms of treatments, he used bloodletting and purgatives but only after other measures had proven unsuccessful. He prescribed medicinals such as emetics for those deemed insane.

Hippocrates inaugurated the first classification of mental disorder, one based on rational criteria. This included epilepsy, mania, melancholia and paranoia. Along with his followers, Hippocrates made the first attempt to understand personality in terms of the humoral theory. So the legacy of Hippocrates is a significant one, but in terms of our focus on recovery in this study what does it have to tell us? The notion that nature decides on matters of disease (almost in a deterministic sense) is a powerful idea and one which is anathema to most modern day writers on recovery, for whom freedom and autonomy are central. If nature decides, then individuals cannot be held responsible for their own health. As the interpreters or assistants for nature, the physicians are responsible for the patient's health but that responsibility needs to be exercised ethically. As Hippocrates famously insisted "If you can do no good, at least do no harm". In terms of our understanding of recovery, responsibility is situated in nature and the physician. While Hippocrates was interested in the course of illness and particularly prognosis, he did not differentiate between the levels of responsibility as the illness progressed except in the types of supportive therapy on offer. He certainly viewed others as moral agents with self-identities based on his view that consciousness was present. However, he saw the brain as fundamental and wrote of how it is the brain which gives rise to our pleasures and pains and the brain that was the interpreter of consciousness. Recovery for Hippocrates was possible, therefore, but it needed the physician to identify, through correct clinical observation, the disease the person was suffering from and apply the correct treatment and supportive aides (particularly for those with chronic disorders). While we may scoff at the underlying humoral theory, the notions of recovery are very much those of modern medical practice.

The psychiatry of the Middle Ages, as Alexander & Selesnick (1967) indicate, can scarcely be distinguished from prescientific demonology and psychiatric treatment was synonymous with exorcism. The dominant ethos of psychiatric 'services' at that time was supernatural. During the early medieval period, the Christian spirit of charity resulted in some humanity being shown to those with

mental illness. In the later medieval period, these early Christian ideals were debased to the point where reliance upon authority and supernatural explanation for diseases characterised psychiatric care and it became indistinguishable from demonological exorcism. However, running parallel with this demonical tradition was a layman's perspective on mental disorder as originating in emotional upset. Some of the poems of the period certainly indicate a connection between emotional upset and mental illness. However, whether the result of demonic possession or emotional upset, during the early medieval period, care for the mentally ill was viewed as a community responsibility. Towards the later medieval period the mentally ill were viewed as witches and they were subject to considerable persecution. The later period in particular, held the person who was mentally ill as completely responsible for their state. The work of Augustine (1982) – constructive and important in so many other areas – can be seen to have had a role in the psychological responsibility levelled at the mentally ill. Augustine provides a deeply insightful work that links his own personal faith, ethics and psychology. In a profoundly Christian period, that psychological insight focuses on his fall from grace and the sins which he feels a need to confess and in so doing, the need to accept responsibility for his sinning. If Augustine is responsible for his sinning, the reasoning goes, then so are others whose sin is demonic possession because in some way they have brought that condition upon themselves.

The Renaissance is often seen as the period of rebirth in science and philosophy. Paracelsus (1491-1541) was the most renowned physician of his day and he had a particular interest in psychiatry. In 1520, he wrote an influential book called *Diseases which lead to a loss of reason*, which was published in 1567 (Paracelsus, 1958). The book makes it clear that mental illness is not caused by spirits but by natural diseases. He created a new classification of mental diseases to replace the classical triad of mania, melancholia and phrenitis, namely the classification: epilepsy, mania, true insanity, St Vitus' dance and *suffocatio intellectus* (the old hysteria). He divided epilepsy into five types. He reasoned that mania consisted of a disturbance of reason and not of the senses, and he thought there was a tendency to relapse and that the disorder could be primary or secondary. True insanity, according to Paracelsus was a permanent state related to the stars. He differentiated five sub-groups: *lunatici, ansani, vesani, melancholici* and *obsessi*. The whole emphasis of Parcelsus's work is away from psychological understanding towards a chemical

understanding and a chemical view on recovery for some conditions that we would now classify as medical. Given his view that true insanity was a permanent state, the idea of recovery was simply not present. There are echoes of this notion of recovery through even the Victorian period.

Paracelsus is important for changing the emphasis on clinical intervention and naturalistic understanding. The implications of this change in the early and later medieval period are also marked in the way people with mental illness were treated. As Foucault (1965) has poetically described it, from being treated with neglect in the early medieval period, when they were seen as part of a community but somehow pushed to the fringes, the mentally ill through their lack of reason were moved on. Thus emerged the idea (part mythological) of the 'ship of fools' which captures this idea very well. The idea that the mentally ill were moved on to other places – sometimes literally by ship - was a powerful image of the period. As the medieval period moved into the 'age of reason' the mentally ill were seen as undermining the very foundations of that society and hence commenced, in Foucault's words, 'the great confinement'.

In many respects the ideas taken from Hippocrates and Parcelsus were still current into the eighteenth century. The philosophers of the enlightenment were particularly concerned about the mad. In an age when reason is held to be the greatest good, those without reason are accorded great sympathy. The optimism of the philosophers and natural scientists was boundless. Those without reason could be cured. Recovery from mental illness was possible. The fatalism of the Middle Ages and the Renaissance was overthrown. These startling advances came towards the end of the eighteenth century when asylums were opened throughout Europe.

Foucault would interpret this opening of the asylums as the need to control and manipulate those not possessed of reason. Others have seen the motivation for their opening in the extensive abuses occurring in the private madhouses. In Britain these madhouses were essentially unregulated until 1774 when an Act to regulate them was passed in the British Parliament. There is a considerable body of literature, mentioned in Jones (1972) to attest to the neglect and mistreatment that occurred in the Madhouse system during this period when restraint was of a very brutal nature. There was growing interest during the eighteenth century in the plight of the mentally ill and the very public difficulties of George the Third helped to increase public

interest. William Battie's[4] work from this period was based on his clinical experience rather than on speculation and he pointed out that there could be spontaneous recovery without treatment (an idea finding interesting parallels with current notions in the recovery approach) and that vigorous purging and emetics could be harmful. Nevertheless, responsibility for someone's recovery from mental illness was still seen as the physician's.

'Moral management' was an approach to care and treatment that dates from this late eighteenth century. Moral management, which in many respects can be seen as a form of psychological treatment, had aspects of both illness and wellness focus. Introduced into the early madhouses such as the York retreat and the Bicetre in Paris, it was concerned to lessen abuses and introduce more respect for the client. In that sense it involved psychological treatments such as strengthening and assisting the client to control their own illness, applying measures to improve the general comfort of the individual and using restraint only when necessary. A principle of separating cases was enforced: incurable and curable for example. Discipline and good behaviour were insisted on, but chains or corporal punishment were not to be used or threatened. Instead, an atmosphere in which the loss of esteem of others was something to be concerned about encouraged a form of self-restraint. The moral management approach also used methods now used in wellness-based programmes: diet or healthy eating, exercise, relaxation and talking about issues. Implicit in such an approach is the assumption that those in need of assistance are able to exercise more responsibility for their own wellbeing.

As the nineteenth century progressed the asylums started to fill. They filled at a remarkable rate. As documented by Jones (1972)[5], the trickle became a flood and towards the end of the century they were running over capacity. The significance of this for recovery is that many of the initiatives which had characterised moral management – individualised care, humane treatment, listening to the client – became impossible due to the growth in the numbers of clients.[6] The expansion in attempts to describe and clinically account for disorders also increased during the period. These attempts can be seen to have reached their zenith in the work of Kraepelin (1856-

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[4] Mentioned in Shorter (1997)
[5] A New Zealand perspective on overcrowding can be gleaned from Williams (1987) who provides insight into the history of Porirua Hospital, Wellington.

1926) who developed a powerful clinical classification system. His achievement was to have constructed the three fundamental forms of functional psychosis in use today: dementia praecox (later termed Schizophrenia by Bleuler), paranoia, and manic-depressive psychosis. In terms of recovery, the period was marked by its separation of the curable from the so-called incurable. It was also the period that stressed the importance of expertise and the role and responsibility of the expert. Indeed clients or patients had little responsibility for their own recovery.

Psychoanalysis represented a major change of emphasis within psychiatric services. The psychological illness model moved centre stage displacing the biological approach. Freud and Jung, the initial developers of the approach, shared many assumptions but they did have important differences. They both believed that the unconscious represented an important vehicle for helping individuals to recover. However, Freud was a strong determinist (and reductive in his psychological approach) whereas Jung was more holistic and open to a causal role for human moral agents. In their views on the responsibility of the clients they saw, they also had differences. While they were both committed to the central role of the interpretative expert, they differed in terms of how much they saw the client as responsible for their own health. Jung thought that the individual client was responsible for integrating the unconscious back into their conscious awareness, a process he termed 'individuation,' whereas Freud was less clear in his views concerning responsibility derived from his deterministic perspective. The psychoanalytical period was, however, a continuation of the clinical-expert ethos commenced under the biological period of the Victorians.

Psychopharmacology and biological approaches became increasingly important in the twentieth century, eventually displacing the psychoanalytical approach. From Iminodibenzl (mood modifier), phenothiazine (forerunner of the neuroleptics) and Paraldehyde (sedative) in the late nineteenth century and early twentieth century, to the middle of the century there developed the neuroleptics, the antidepressants, the anxiolytics, Lithium treatment and mood stabilizers. In parallel with these pharmacological developments there were a number of biological approaches in the same period. Surgical practice revealed that interrupting the connections of frontal lobes produced docility. This was useful in very disturbed

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[6] As Shorter (1997) has indicated, there remains debate as to whether this increase in numbers was caused by an increase in illness during the period or whether it was due to an increase in intolerance towards people seen as 'different' from others.

patients (particularly for clients not responding to convulsive therapy or deep insulin therapy). Electro-convulsive therapy was found to have beneficial results for some patients and it continues to have a place in the psychiatric armamentarium. In terms of recovery, all these approaches tended to shift responsibility on to the treatment intervention and away from either the professional or the client. Hence we have the beginnings of an emphasis upon procedural techniques rather than the expert as such, though the clinical judgement of the expert clinician continued to be a central focus during this period.

Starting in the 1960s, the anti-psychiatry movement began recognising that psychiatry had a political role and significance. Anti-psychiatry was essentially the view that institutional psychiatry had somehow gone wrong, particularly in its reliance on psychiatric classification and 'unproven' biological treatments. Some adherents of the anti-psychiatry movement held particular views about the causation of mental illness, usually adopting a social causation theory. Clients in the large psychiatric hospitals were accorded increasing rights as new civil rights legislation[7] was passed. As Sedgwick (1982) has indicated, there were four main thinkers responsible for this politicisation of psychiatry: Goffman, Laing, Foucault and Szasz[8]. While these four writers were fundamentally different in many respects, they shared a social perspective on mental health and rejected the categorical classification approach with all its assumptions. Indeed, they all shared the view that mental disorder as then conceived in the classification systems was misguided. Many of their assumptions[9] about responsibility lay within a social theory context (though Szasz is an extreme libertarian individualist); and they thought that recovery can only be understood within a social environment. The recovery approach accepted many of the ideas of the anti-psychiatry theorists and in a consequence of this social bias the recovery approach found it more difficult to be fully integrated into clinical as opposed to non-clinical services.

From the late 1960s, the large asylums stated to close (as quickly as they were originally opened two hundred years earlier), a process known as

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[7] The period saw the coming together of three strands of thought and activity: the open door policy in psychiatric hospitals (and away from locked units); and new powerful medication and civil rights legislation which started to accord increased rights, checks and balances to those under the Mental Health Act.

[8] For an interesting work on some of the practical realities of these anti-psychiatry views, Baron (1987) charts her experiences in a psychiatric day hospital based on a therapeutic community using ideas from Goffman and others as it moves from a therapeutic ideal to a totalitarian system.

deinstitutionalisation, and as the institutions closed there was a need for community care. It could be argued that the asylums created relationships of dependency and that responsibility was removed from clients. As the asylums closed these relationships were changed. Clients were suddenly decanted out into their local communities. There were a number of stepping-stones to assist clients with their transition to community living: half way homes, supported homes, independent flats, rehabilitation hostels, day hospitals and the like which were all designed to make the transition easier. In many cases, however, neglect became normal, mirroring an earlier period in psychiatric history. This decanting of long term (and other) clients out into the community did not mean clients had recovered. In some ways, the initial period of community care was a period characterised by maintenance therapy, that is to say the idea was to maintain the mental state of clients such that individuals would not need to go back to hospital.

The 'survivor movement' began as a way of respecting the experience of those clients who had been in the large asylums and then 'survived to tell the tale'. It was a consumer-based movement concerned not with symptomatology but with individual experience: what helped, what did not help. As will be discussed in the next chapter, the individual experience of the client tended to be primarily focused on the client's understanding of functioning. Helped by the politicisation of psychiatry, many of these 'consumer movements' had an explicit political agenda: to end psychiatry, to develop alternate methods, to create self-help movements etc. Perhaps the most lasting impact of the survivor movement was ethical. It gave consumers a voice, one they would never lose again. In giving 'consumer movements' a voice, it started the transition of power and responsibility towards the client and self-determined approaches to recovery and away from the professional. That ebbing tide of professional power is very much the characteristic of our time.

While most histories of psychiatric services emphasise the way that biological and psychological models have dominated at various times, and while the psychological approach to illness has certainly had an influence on the development of the current recovery approach, few histories emphasise the role of magic and the supernatural in that history. Alexander and Selesnick (1967) are an exception to this. They note that magic and the supernatural have always had an important role in the

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[9] Laing and Cooper (1971), in particular, accepted an existentialist philosophy.

history of approaches to mental illness. From primitive medicine and demonology to homeopathic, imitative and mimetic magic there have always been practices which relied on principles such as similarity (i.e. because things look alike they must be in sympathy with each other) and contiguity (i.e. where there is continued action upon each other of things once close but now separated). Our current era has a number of new age and supernatural practices (some of the evangelical churches for example) which draw heavily on these two principles for their effect. There has been, and continue to be, revivalist religious views which have contributed ideas about hope, faith and charity as central to recovery. The current emphasis within recovery discourse on future-orientated projects rather than the illness experience would seem a development of this hope-orientated approach. The impact of these approaches to recovery has been profound (if not always helpful). Magical and supernatural thinking have had an impact on the recovery approach through the emphasis on wellness; the belief that adopting a particular mental state will inevitably have a causal relationship to the presence or absence of mental illness; that individuals are completely free to choose; that there are mysteries in the universe that can be adequately understood outside the scientific paradigm - all are hallmarks of a magical perspective when combined. Such thinking shifts responsibility towards the client, but only to a limited extent, since there are still thought to be intermediaries who can interpret magical events as experts.

The culmination of much of this previous history in terms of recovery is the self-help movement. This self-help movement has used bibliotherapy as its main vehicle. The publication of books on how to have good mental health and how to be happy has proliferated. There is a long tradition, all the way back to Samuel Smiles' (1958) '*self help,*' of self-help literature. The emphasis in this self-help literature is on individuals assuming responsibility for their own health and wellbeing. This approach may work with those who experience mild or even moderate symptoms; however, for those with severe symptoms it is more problematic. There has also been a growth in self-help groups and organisations; such organisations as GROW, which is a self-help organisation which believes professionals can be unhelpful at a certain point in someone's recovery journey.

Wellness accounts of mental health have become increasingly important since the Second World War. These accounts commence with trying to understand mental health, rather than with trying to treat mental illness. Much of the work in this

regard has come from public health measures (that is, the nature of healthy relationships, anger management courses, stress relief etc.) rather than psychiatric services. However, such measures have mainly been at a population health level. In the past decade or so, the role of some of this mental health work has become important in primary health and the self-help strategies mentioned above connect with this development. While there is a connection between primary mental health problems (that is mild and moderate problems) and psychiatric services (for serious mental illness), the applicability of mental health models to psychiatric services remains problematic.

Section Two: The Recovery Approach

The recovery approach is the final development in the historical background of recovery to the present day. The origins of the recovery approach appear to be a blending of several historical streams, which I have already discussed: the survivor movement, wellness accounts of mental wellbeing, supernatural/magical accounts, anti-psychiatry accounts (at least in the early and middle phases) and ideas drawn from existentialism which I will discuss later. While the recovery approach is a new development, it is possible to see three phases to its current developmental stage, early, middle and late.

Early Phase: The emergence of the recovery approach in modern times was closely connected to the survivor movement. Those who had survived the asylums and the psychiatric regime saw recovery as being as much about recovery from the psychiatric system as about recovery from mental illness. This is perhaps understandable given the therapeutic methods of the late asylum system, which were, in Goffman's (1961) memorable phrase, 'total institutions': that is, all aspects of someone's life could be, and usually were, regulated by the asylum: what people ate, what time they got up, went to bed, who they saw and when visitors were allowed, how people spent their time and so on. Parallels have been made with prisons and even concentration camps. While prisons and concentration camps share the total institutional framework of the asylum they were not motivated by explicitly therapeutic ideals. In practice, the asylums did have punitive outcomes for many clients, but in most cases that was not the intention.

The early phase of the recovery approach was connected to the deinstitutionalisation and community care period. As the asylums closed, they were

replaced by rudimentary community services, which, in part because of poor resourcing, found themselves with a difficult task. Hence they tended to emphasise maintenance over all other objectives. The main aim was to keep people out of hospital and to maintain clients in the community. This tended to be the hospital regime transferred to the community. It was uncritically disorder-focused and clients and new consumer groups were critical of it. During this early phase, there was increasing focus by consumer groups on a better term than 'patients' to describe them as a collective. The terms clients, users, and consumers became more fashionable.

The early phase of the recovery approach tended to adopt social learning approaches to mental illness as Sedgwick (1982) has indicated. Ideas came from Goffman (1961) (labelling theory), Szasz (1961) (that mental illness was a myth), Laing (1965) (that we could learn from psychosis and be richer for it) and Foucault (1965) (that psychiatry was a social police force). It tended to embrace new age thinking in the 1960s (particularly connected to experiments in living). There was also an influence from revivalist evangelical thinking and ideas overturning long-cherished theological ideas. There were also (not always consciously understood) influences from wider societal events in the sixties: the increase in civil rights and alternative lifestyles and ways of living. There were also ideas, such as existentialism, which have had an important role.

Existentialism[10] – certainly in the form espoused by Sartre (1969) – was gaining traction in the 1960s. *Being and Nothingness* had been published in English for the first time at the end of the 1950s. While that book was not itself about ethics or psychiatry explicitly, existentialism and ethics have been linked to existentialist schools of thought in psychiatric practice. There were three main reasons for the influence of existentialism upon the early phase of the recovery approach. Firstly, existentialism had entered mainstream culture. Secondly, existentialism had a particular impact upon psychiatric practice, giving rise to existential psychiatry which was seen as being at odds with traditional psychiatric practice. Thirdly, it connected with the antipsychiatry movement.

The two fundamentally important ideas from existentialism that gained currency and influenced the recovery approach were firstly that being in itself (quite

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[10] Sartre is probably the most important thinker in terms of existentialism; but while *Being and Nothingness* is arguably his most important philosophical work, it is his own fiction and the work of Camus who have popularised existentialist ideas.

apart from what it does) is a foundational idea. Even if someone had not read *Being and Nothingness* (which would have been the majority) and hence understood the notion of Being-in-itself and Being-for-itself, the idea of Bad Faith was certainly widely grasped, if not always for the correct reasons. Bad Faith would be seen by many as living inauthentic lives. The apparatus of the state and the rules and regulations of the state were in need of dramatic change because they helped to reinforce inauthenticity. The same revolutionary concepts (as opposed to evolutionary thinking) were present in the early recovery approach thinking. Additionally the idea of freedom, particularly the radical freedom that individuals were free to make themselves afresh and make their life over, was a very attractive notion. Unfortunately, much of existentialism was anti-rational, anti-scientific and even anti-political. Some of those roots would also influence the recovery approach.

The early phase of the recovery approach was characterised by paradox perhaps more than anything else. While the consumer groups and others who saw themselves as involved in a movement developed, they did not in the early phase refer to themselves as taking a recovery approach. This came later. In the early phase, they were criticising the professional dominance of psychiatric services[11].

Middle Phase: The middle phase in the nineteen seventies could be characterised as a period of challenge to the existing order in psychiatric care. This was a period (in Europe and North America)[12] of community care. There were, increasingly, publications of the experience of those who had lived through psychiatric care (particularly asylum care). The experiential nature of recovery easily connected to the central notions of existentialism around 'being' and 'freedom,' and hence the continued anti-psychiatry emphasis of much of the writing in this period. During this period, recovery became an approach characterised by a focus on the self-determining client, and as something a client chooses for themselves. This influenced teaching and research in some of the main academic centres, particularly rehabilitation courses. However, it was still a repressed discourse. Perhaps because of the centrality given to experience (i.e. Beingness) and to freedom, psychiatry was seen as trying to alter people's experience through mind-altering substances and as wanting to imprison people. The ideas of some of the humanistic psychotherapists,

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[11] Wolfensberger (1972, 1983) has provided one of the best attempts to move away from a professional dominance of human services, and his earlier writing dates from this period.

such as Rogers (1967), for example, were also very influential. The notion that we are all on a journey and grow and develop as people and that we can learn from our experience of ill health was very a very powerful one. Unfortunately, that journey was seen as something best done without professional help.

Later Phase: This phase of the recovery approach is one we are currently living with. It is characterised by official endorsement and official publications, emphasising that recovery is now a dominant discourse. It is marked by consolidation of the recovery approach in non-clinical settings but by a continued struggle and challenge with existing clinical services; this struggle being essentially concerned with the differences between a professionally determined and a client-determined understanding of recovery. The recovery approach is now taught and is seen as core training for all psychiatric professionals. As already mentioned, however, this approach is currently delivered through the procedural ethos, which itself has an historical background, which will be discussed next.

Section Three: Ethos of Psychiatric Services

The aim of this section is to provide a brief history of the ethos of psychiatric services. An ethos is the way a particular community sees itself and organises its activities and procedures. Psychiatric services have had a changing ethos for the past two hundred years. An ethos changes for many reasons: partly in response to societal changes; also because of changes in technology or science; and finally, because of new theories or art forms. An ethos is the prevailing way of doing things, the spirit of a community. An ethos provides a framework, one that is available to all members of that community. A framework may not be something which practitioners in that service are aware of at the time, but it provides an orientation in 'moral space', to use Taylor's term. Taylor (1989) provides an argument for the inescapable nature of frameworks: that is that frameworks provide an orientation for people and thereby a sense of identity. They also need to be contrasted with individual beliefs or ethical positions: there may be many different ethical and clinical views within a particular service, like psychiatric services, but there will only be one ethos. I believe that there have been four types of ethos in the past two hundred years in terms of psychiatric

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[12] New Zealand's experience of community care started over a decade later than Europe and North America.

services: a superstitious ethos, a utilitarian ethos, a clinical-expert ethos and a procedural ethos.

The current recovery approach, discussed in Section Two, has not managed to become an ethos, since currently a procedural ethos is in place within psychiatric services. In order to understand how we can change the ethos of psychiatric services towards a recovery ethos, it is vital to understand how the ethos has changed down the years. That will be the focus in this section.

The superstitious ethos: from the Middle Ages until the late eighteenth century, care of the mentally ill was characterised by neglect and abuse in consequence of a prevailing view that mental illness had supernatural causes. This is not to say that there were not pockets of care and concern, only that the ethos was characterised by a focus upon the supernatural. The neglect and abuse of this period was perhaps based, as discussed in earlier sections, on the mad as fundamentally different and other and as not possessing reason or the faculty of reason. Unable to relate to what was viewed as unreasonable, this period neglected the mentally ill. In equal measure, however, it also abused its mentally ill. The mad, the unreasonable, were to be chained, were to be exorcised of demons, were to be 'treated' with bleedings and the like. At the time this was not seen as abuse, but from our present day perspective many of the practices were abusive. The private mad houses, in particular, were very abusive as a consequence of seeing the 'mad' as fundamentally different and the state realised it would need to intervene and regulate. This focus on the mad as fundamentally different helps to explain the beginnings of the emphasis upon professional ways of fostering recovery, since the mad – it was thought at the time – could not be expected to have any reasonable views on the matter themselves.

The utilitarian ethos: The regulation of the modern state in the area of psychiatric services led to the modern asylum and to the removal from society of large numbers of those deemed mentally ill. The utilitarian ethos was concerned with the benefit to the majority of society incurred by the removal into asylums of a minority of those deemed mentally ill. The removal into asylums, fostered by the utilitarian ethos, created dependency in psychiatric care. For, in placing people in the asylums, there was little expectation that people would come out and they were usually placed in a 'total institution' for a prolonged period of time. The result was the dependency of those being cared for. This dependency produced a vicious cycle: those who were dependent became progressively less able to do anything for themselves and hence the

need for more dependency-producing measures and the concomitant increase in learnt helplessness. Dependency was underpinned by an uncritical acceptance of a utilitarian ethos, one that saw ever-increasing numbers removed from society and placed in the asylums. The individual and their needs became increasingly irrelevant to the perceived need to generate the best outcome for the majority and that outcome would be generated by increased regulation and control and paradoxically increased dependency.

The clinical- expert ethos: The utilitarian ethos lasted for much of the nineteenth century but at some point, difficult to locate exactly, the role of the expert within the asylum became critical. Perhaps because of the numbers of people, the need to categorise and prioritise care, the need to make sense of the increasing power residing in the medical superintendent, the role of the 'expert' in psychiatric care became central. The clinical-expert ethos, which lasted well into the twentieth century, saw an uncritical acceptance towards the views of that expert – generally a psychiatrist – and an inability to challenge that viewpoint and with it an associated acceptance of paternalism. The clinical-expert ethos had an underpinning assumption that the expert had a duty of care to their patients and this extended to all aspects of care with an associated understanding that there was no place for clients to exercise their views or voice their concerns. The clinical-expert ethos also meant that the expert in psychiatry needed to look like an expert from other areas of medicine: hence the need for a body of knowledge and recognised control over that body of knowledge. From our previous discussion of history, particularly the rise of psychoanalysis during this expert period, we can see how psychiatry had no alternative but to take control of psychoanalysis in some form if it wanted to extend the clinical-expert ethos, because it could be argued that psychoanalysis as a body of knowledge has little direct connection with traditional medical practice. The only obvious connection is that it meant an extension to the era of the expert psychiatrist. In this ethos, recovery meant recovery as determined by the psychiatric professional against professionally determined standards. These professional ways of viewing recovery within the clinical-expert ethos tended to rely upon purist approaches, whether they were biological or psychological in origin, rather than eclectic approaches.

The procedural ethos: This is the current ethos of psychiatric services and is characterised by an emphasis upon processes, procedures and protocols that are

fundamentally derived from a number of simple principles. For example: firstly, the principle of justice – namely how do we ensure prompt referral, fair treatment and reasonable access for all those deemed to be in need using all treatment approaches equally? Secondly, in terms of the principle of autonomy, how do we promote autonomy within the confines of a system where the Mental Health Act (1992) can be applied? These may seem reasonable principles, but as I will show in Chapter 4, the focus on principles, and procedures which rest upon them, tends to result in less focus on what the client can do to help their own recovery. This focus on principle-based procedures has generated a particular understanding of recovery, namely an eclectic approach to fostering recovery[13] to deal with radically differing views on how best to help someone recover. The procedural ethos has arisen from a convergence of the clinical-expert ethos (and differences between those experts) and the new recovery approach. Confronted with the need to listen to the client's perspective and to adopt client-centred approaches, the clinical-expert ethos changed to become a procedural ethos where 'expertise' was increasingly centred in protocols, guidelines and research generating 'evidence-based practice'. The expert became an interpreter and, in some sense, a custodian of those pathways and evidence. The recovery approach that is concerned with individualising care had to contend with a system that had become concerned with rules and protocols. Research and particularly the Randomised Control Trial (RCT) presents a good example of this quandary[14]. The RCT is seen as the gold standard in research, but its results about the efficacy of medication, for example, do not show how *this particular client* will respond, it simply gives a statistical probability of how clients in general will respond and what side effects in general they will experience. Procedures have always been a part of psychiatric services and they always will be. What is new is that now procedures are the dominant feature of the system. The expert had previously decided when someone needed to be placed in hospital; increasingly this decision was placed within the rules of legislation or policies, for example the Mental Health Act. The result was a procedural ethos, but one which continued to use the language of the recovery approach.

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[13] An eclectic approach to fostering recovery holds that client self-help and professional approaches to recovery should all be treated equally in each phase of a client's recovery and that in a procedural ethos this is done through procedures and protocols.

[14] Fulford & Howse (1993) provide a useful ethical analysis on the role of research with the clients of psychiatric services

The expert, worried by increasing litigation and concern about 'ultimate responsibility', has been quite content to allow procedures to become the final arbiter of responsibility. In a risk averse climate, this has meant the role of the expert has changed to become more an interpreter of a body of knowledge, itself subject to numerous guidelines and protocols.

Society has been changing too. The old deference towards perceived authority figures has been breaking down. Nothing is now taken at face value. The psychiatric expert, more than most, has had to contend with a better-informed public and client base. This has meant the expert has had to share some responsibility – if only for educational issues – with those they see and care for.

Summary

This chapter provides a brief historical background to the concept of recovery. This is in order to show that the notion of recovery has changed over the centuries from a focus upon purist, professionally determined understandings of recovery to a current eclectic approach to fostering recovery within psychiatric services.

Section One argued that the notion of recovery from mental illness is closely connected to the history of psychiatric attempts to help people. I have shown that in psychiatric history there have been alternating biological and psychological illness models of recovery, which have used a purist professional approach to fostering recovery. Quite apart from the empirical issue of whether these approaches worked, they do represent a dominant discourse for the concept of recovery and they helped to associate professional psychiatric approaches with recovery. So successful has been the connection between professionalism and fostering recovery that many people see professional views on fostering recovery as providing a complete account of recovery.

The recovery approach, with its emphasis upon a client self-determined approach to recovery has developed in response to the strong identification of professional approaches with recovery. As was shown, the recovery approach is a blending of several streams: wellness approaches, supernatural/magical approaches, anti-psychiatry and existentialism. The recovery approach can be seen to fall into three phases of development that were termed early, middle and late. The early phase was characterised by the emergence of the recovery approach amongst survivors of

the psychiatric system, where recovery meant not simply recovery from mental illness, but recovery from the effects of the psychiatric system. The middle phase was characterised by the challenge of the recovery approach to the dominant professional discourse with its objective and expert-driven care. This challenge occurred at many levels: political, social, academic and clinical. The term 'recovery approach' entered common discourse during this period. The later phase, which is the current phase, is concerned with consolidation of the earlier phases and with the recovery approach becoming a dominant discourse. This it has succeeded in achieving, but psychiatric services continue to function in ways that have not fully accepted client perspectives. This is because of the prevailing ethos within psychiatric services being based on a procedural ethos, which itself provides a framework which supports eclecticism. In this ethos, the recovery approach simply becomes another part of the eclectic mix, requiring procedures.

The chapter has traced the way the ethos of psychiatric services has changed during the past two hundred years. It was shown that in the late eighteenth century the ethos was one of superstition towards those with mental illness. This ethos changed as the asylums were built and filled, to become a utilitarian ethos. The large asylums were 'total institutions' and regulated all aspects of inmates' lives. The utilitarian ethos changed in the late nineteenth century to become the clinical-expert ethos. This ethos was characterised by a reliance on the clinical judgement of the expert and the passive nature of the patient. This ethos came under challenge from the recovery approach and has changed in the past few decades to become a procedural ethos, and the role of the expert (though still important) has become subservient to policies, procedures, ethical codes, rules, legislation and a form of eclecticism: the paradigm case was that of the Mental Health Act, which affects a small number of people, but which is closely determined by rules and procedures. The argument has been that in a risk averse climate the expert has permitted rules and procedures to become the final arbiter of decisions. The expert clinician has done this partly as a way of preventing legal action, but also as a way of ensuring that their expert judgement is seen as part of accepted practices rather than as something they should be held accountable for.

The next chapter will clarify the concept of recovery and how it will be used for the rest of the thesis.

CHAPTER 2
Clarification of the Concept of Recovery

This chapter will provide some conceptual clarification of the concept of recovery within psychiatric services, which will then be used for the remainder of the thesis. I will be arguing that basically the term 'recovery' in this thesis describes an improvement in mental health of a client with mental illness. While it is possible for clients and professionals to broadly agree on the criteria for ascertaining what needs to improve in recovery from mental illness, there remains considerable disagreement about who determines what should be included in those criteria. It will be argued that both professional and client perspectives need to be included.

Firstly, issues of definition in connection with recovery need to be considered. This is important because of the confusion that surrounds the word and the way in which it is used in practice. The language we use in discussing recovery is important if we want to make ourselves clear. Clients and professionals routinely talk about a client's recovery, or the client's need to recover and of individuals who have recovered. In this instance the recovery approach is not included since I will return to it later. This array of terms can be very confusing, particularly when we find different things are meant by the term.

To recover is defined in *The Little Oxford Dictionary* (1986, p.454) as to "regain possession or use or control of; come back to life or health or normal state or position". To recover in this sense means complete recovery, in regaining possession of and coming back to a normal state if we are referring to the client's overall mental health. This should be contrasted with recover in the sense of regaining particular skills or competencies. Overall recovery, or recovery restricted to one skill, can be either partial or complete. When we use words like 'recovered' we are meaning some final end point has been reached and this should be contrasted with words such as 'recovering' which does not have that sense of finality, but is more about a degree of improvement.

Recovery from mental illness is not necessarily linear (indeed, it is not usually so). My focus is not on recovery as a final end state, since recovery will continue in an open-ended way. The point is that recovery needs to be seen as part of a continuum in contrast to a categorical understanding of recovery (that is either/or). In a continuum, there is more or less of something rather than a categorical distinction.

The realities of the psychiatric professions are such that here I am more interested in the process of recovery so the popular notions of recovery as an end point have less relevance. Recovery in this thesis is defined as involving improvement (in the area under consideration) where the level of recovery at r^2 is seen to be an improvement on the level of recovery at r^1 judged using particular criteria.[1] To speak of recovery is to speak of a client having reached point r^2 on the continuum subsequent to being at point r^1 along the illness-health continuum (see Figure 2.1 below).

Illness$\rightarrow\rightarrow\rightarrow\rightarrow\rightarrow$ recovery $\rightarrow\rightarrow\rightarrow\rightarrow\rightarrow$recovered/health

r^1 $\qquad\qquad\qquad\qquad\qquad$ r^2
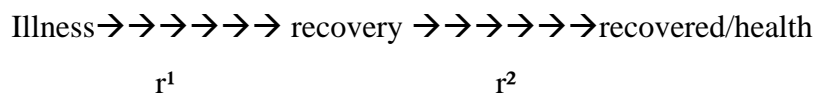
Figure 2.1 *Recovery Continuum*

As Figure 2.1 indicates, there is an implicit sense of a continuum involved in recovery from illness to health with all the (infinite) intermediate positions. The continuum does not need to involve directionality, (for some people there may indeed be a decline) but to talk of recovery is to talk of moving towards health. The movement along the continuum need not be consistently in one direction, there can be relapses, but from a broad perspective recovery is an advance towards health.

Having established that recovery is fundamentally a process concerned with the improvement of mental health, the issue to be addressed is the need to identify what criteria in mental health measure the improvement or recovery of mental health.

Recovery Criteria

There are two broad criteria for determining if someone is recovering from mental illness. There is general agreement on these broad criteria for recovery, but disagreement over who determines whether the criteria are being met, namely disagreements between client and professional perspectives[2]. Recovery involves: (1) a reduction in the symptoms of mental illness; and (2) an improvement in the individual client's functioning[3]. Disagreements in the area of recovery criteria are generally due to differences in perspective rather than differences over the actual

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[1] See Recovery Criteria below

[2] Secker et al. (2002) has a useful discussion on the differences between professional and client views on recovery in the context of employment.

recovery criteria. This difference is most marked between a client and professional perspective, but there are differences in perspective within these two groups. In the last chapter we discussed some of the differing professional perspectives. Some of the intra-group differences for clients will be clarified in a later section of this chapter. Sometimes professionals can adopt a client perspective and sometimes clients can adopt a professional perspective, but it is still possible to broadly talk about a client perspective and a professional perspective. Proponents of the recovery approach have strongly advocated a particular understanding of the recovery criteria in a way that is meaningful to clients. This will be discussed later in this chapter.

We need to differentiate between such criteria and ways of fostering recovery[4], since they are often confused. Fostering recovery is simply the way we can help recovery to occur; in the case of professional approaches, by using biological, psychological and social interventions. Additionally, fostering recovery can also refer to client self-help approaches. Part 3 of the thesis will present the recovery ethos for psychiatric services which provides an overarching philosophy for fostering recovery using client and professional approaches. Briefly, the best way to foster recovery is to use psychological, social, biological and self-help approaches at appropriate moments to help move someone along the illness-health continuum. The way decisions are made about which interventions should occur at any point are determined, not by procedures based on eclecticism, but by people using virtues and other factors to be explained later. I have termed this a pluralistic approach to fostering recovery.

I have referred to the illness-health continuum and next I will consider this continuum in more detail.

Recovery and the Illness-Health Continuum

Recovery is a journey for the client, involving both internal and external factors. Internally there are psychological and physiological processes; externally there is the client's ability to function in the world. This journey occurs along the illness-health continuum. 'Journey' simply refers to the movement along that continuum. 'Illness-health continuum' refers to the way that the events and experiences implicated or involved in the mental illness can be seen to lie along a

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[3] I discuss the concept of functionality in more depth in Chapter 3.

continuum from severe illness at one end to absence of illness and complete recovery of health at the other.

Essentially, when someone has a severe mental illness there are a number of events and experiences that occur (see Chapter 3 for further discussion). There are biological and chemical events inside the brain and at a subjective level, depending upon the type of illness, many unpleasant psychological experiences. The kind of symptoms and functioning a client experiences will be determined by the point the client occupies along the illness-health continuum. As the client continues their journey along the illness-health continuum, if recovery is occurring, the symptoms will start to lessen and functionality will start to return in ways that are meaningful to the client and the professionals.

Crisis   acute   rehabilitation   active recovery   self care   citizenship
--→
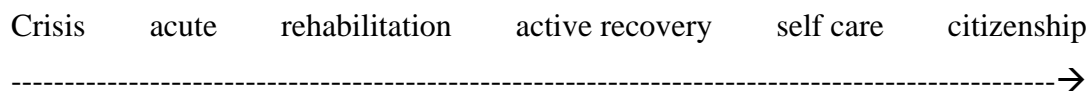
Figure 2.2 *Recovery Process in the Form of Recovery Stages*

Figure 2.2 is a schematic of an ideal recovery journey. It is presented in linear form as comprising a number of recovery stages, which is different to practice where the path would be non-linear and involve recursive loops. This idea of a gradual, even, incremental continuum for recovery is contrasted with the following Figure 2.3.

Client Illness   +   Clinical Intervention   =   Client Health
Figure 2.3 *Recovery Process*

In Figure 2.3 there is a categorical change from illness to health following a particular clinical intervention (almost like the idea of a magic bullet solution). However, Figure 2.2 accords more with individual experience and with empirical studies that support the idea that recovery is a gradual process.

Before moving to a consideration of professional and client perspectives on the recovery criteria, it should be noted that there do seem to be particular critical

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[4] As already mentioned the recovery ethos can be applied to all mental illnesses. In this sense the recovery criteria can apply to all mental illnesses. However, different health domain interventions will be needed to foster someone's recovery from specific disorders such as schizophrenia or depression.

points in a client's recovery journey when recovery can be promoted or not (see Chapter 8 for further details).

Client and Professional Perspectives on the Recovery Criteria

The criteria for recovery may appear clear but professionals and clients have a tendency to see them differently, that is, from a different perspective.

The professional perspective on recovery tends to emphasise the role of the professional in determining whether someone is recovering from mental illness using professional judgement, standardised assessment tools and research. While there are many examples of professional approaches to fostering recovery, they all tend to emphasise a particular understanding of symptom reduction and functionality improvement (while not necessarily agreeing on causation). Warner's (1997) criteria for determining recovery from schizophrenia are a good example. He sees recovery as being about a loss of symptoms of psychosis and return to pre-illness levels of functioning and ability. This judgement is predominantly based on the professional using their expertise. In the clinical-expert ethos this would have been almost entirely dependent on the professionals' judgement.

Clients vary in their perspective on recovery. However, the recovery approach, which represents the most systematic attempt to make sense of recovery from the client perspective, has a perspective which is different from the professional perspective in that there is a broader understanding of what constitutes symptoms and functioning. While some clients would use the professionals' understanding of symptoms and functionality, others would include quite personal 'symptoms' (which are perhaps more correctly seen as problems the illness has caused) such as waking up in an anxious state at three in the morning or being unable to concentrate on cooking their evening meal. In terms of functionality, clients often see their illness in a functional way, as things which they can no longer do; whether, for example, this involves no longer being able to read their favourite book or go fishing as they used to.

Since there is a much wider diversity of views within the recovery approach literature (as opposed to professional perspectives[5]) as to what should be included in the recovery criteria, these will be the focus of the following discussion.

There are four descriptions of recovery in current use from the literature that reflect the dominant discourse around the recovery approach. Each of these descriptions offers, implicitly or explicitly, a number of views on the content of the criteria for determining whether someone is recovering. In the 'recovery literature' these descriptions are presented as 'definitions' of recovery, but they are, more properly speaking, descriptions of how recovery should be fostered or developed with some comments on the recovery criteria added either implicitly or explicitly. That there are so many different views in these descriptions might be thought to indicate that there are few, or no, common recovery criteria. However, all these views can be brought together under the two recovery criteria already mentioned. The purpose of identifying these descriptions is firstly, to show how muddled much of the current recovery literature is between recovery criteria and ways of fostering recovery; and secondly, to show the way that the client perspective can be accommodated by the criteria of symptoms and functioning. Thirdly, it indicates the need for a broader understanding of symptoms and functionality than is conventionally appreciated in the professional literature.

These descriptions are presented in reverse chronological order since this provides a mechanism for appreciating how the Mental Health Commission description (Description 1), which is currently used in psychiatric services, has been based on earlier descriptions[6].

Description 1 (The Mental Health Commission)

Recovery is a journey as much as a destination. It is different for everyone. For some people with mental illness, recovery is a road they travel on only once or twice, to a destination that is relatively easy to find. For others, recovery is a maze with an elusive destination, a maze that takes a lifetime to navigate.

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[5] There are different professional approaches to fostering recovery – i.e. biological, psychological and so on. There is, however, a broad agreement in using those health domains on the criteria for determining whether recovery is occurring.

[6] There are many other descriptions of recovery, but the descriptions presented here are seen as 'classic'. Ralph (2000) has many more of these recovery descriptions.

Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them.

Some people have experienced recovery without using mental health services. Others have experienced recovery in spite of them. But most will do much better if services are designed and delivered to facilitate their recovery. Virtually everything the mental health sector does can either assist or impede recovery (1998, p. 1).

This description of recovery has been, and continues to be, enormously influential within psychiatric services. The essence of the description can be reduced to three propositions:

1. Everyone is an individual and on an individual journey with regards to their mental illness recovery;
2. Recovery occurs when people can live well with or without symptoms of mental illness and the losses it brings;
3. Psychiatric services (and other mental health services) have a vital role in assisting people with mental illness to recover.

The fundamental message of this description is that recovery is something the client determines for themselves using their own interpretation and experiences with the assistance of psychiatric services where appropriate, since recovery involves "living well" and this is something the client decides upon. The three main propositions will be considered more closely.

It seems that the first proposition is a true statement; it is not an empty statement, since until recent times the notion that mental illness affected people in unique ways would have been strongly resisted. It is a statement which is making a claim about mental illness, but which is neither a criterion of recovery nor a way of fostering recovery. As will be clear as the thesis progresses, this first proposition is one I find very attractive. The third proposition also appears hard to criticise. However, there are those (i.e. Curtis (1998) and Deegan (1997) in some of the following descriptions) who limit the significance of psychiatric services in recovery[7].

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[7] However, in the New Zealand context, this third proposition is somewhat limited in that, until the Ministry of Health's *Primary Health Strategy* (2001) was published, there was an expectation that

This proposition is not a criterion, but a means of facilitating recovery. However, the main critique of the description can be levelled at the second proposition: that recovery occurs when people can live well in the presence or absence of the symptoms of mental illness and all its losses. This is a view that is concerned with the criteria for recovery and not with ways of fostering recovery. "Living well" can be seen as connecting to functioning since "living well" at one level is simply a way of saying someone is functioning well. However, the proposition also connects to the other recovery criterion, namely the presence or absence of symptoms. By connecting living well with symptoms as the proposition does, there is still an acknowledgement that improvement in both recovery criteria is important. Even if all that is really meant by this is that living well with symptoms is better than living badly with symptoms, giving greater prominence to functioning over symptoms is a constant refrain from the recovery approach literature.

Description 2 (Curtis)

> Recovery is a process, not a place. It is about recovering what was lost: rights, roles, responsibilities, decisions, potential and support. It is not about symptom elimination, but about what an individual wants, how s/he can get there, and how others can help/support them to get there. It is about rekindling hope for a productive present and a rewarding future – and believing that one deserves it. Recovery involves people having a personal vision of the life they want to live, seeing and changing patterns, discovering symptoms can be managed and doing it, finding new ways and reasons, doing more of what works and less of what doesn't. Recovery is about reclaiming the roles of a 'healthy person,' rather than a 'sick' person. Recovery is about getting there (Curtis, 1998, p. 17).

This description has been influential amongst consumer groups and within rehabilitation services and picks up on many of the points made in the three propositions of description 1; namely an emphasis upon the individual journey as a way of facilitating recovery (i.e. "a process not a place"); and an emphasis upon

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psychiatric services would provide services to only 3% of the population with serious disorders and that primary services in the form of General Practitioners would service the rest. While primary services need to be included as part of 'other mental health services,' because most primary services are provided by General Practitioners, who share the medical world view of psychiatry, the same justice- dominated procedural ethos applies.

recovering what was lost and not symptom elimination[8]. There is an acknowledgement that recovery is about discovering the way "symptoms can be managed and doing it" which is also an acceptance of the need for improvement in respect to this criterion. This is because symptoms that have been discovered and managed are clearly an improvement on those that have not, even if they are symptoms "only" from a client perspective. However, the description makes no mention of the place of psychiatric services and instead emphasises the individual's own responsibility for self empowerment. Self empowerment can be seen as connecting to the functionality criterion. It is for the individual to have a "personal vision" and to reclaim the roles of a healthy person rather than a sick person and be hopeful. This component would seem to connect more with self-help approaches to fostering recovery.

As a description, it could be argued that it places too much emphasis upon the individual and too little upon the various services and supports which are available. For those individuals able to shoulder the weight of personal responsibility – and able in Fromm's sense to have no fear of personal freedom to exercise that responsibility – such a description would probably be adequate. However, for those individuals who have particularly severe symptoms, or who lack the necessary personal vision and discipline, such a description would probably add to their losses in that they would potentially see themselves as having lost the ability to recover by themselves.

A similar description from a year earlier and influential for both descriptions 1 and 2 has been Description 3.

Description 3 (Deegan)

> Recovery is, in part, emerging from an individual, rather than being imposed upon an individual. The goal of recovery is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of disability. The aspiration is to live, work and love in a community in which one makes a significant contribution (Deegan, 1997, p.18).

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[8] In other work, Curtis has continued to emphasise these points, see Curtis (1997, 1999).

This description also alludes to themes similar to the other two descriptions but emphasizes the ways in which recovery can be brought about. It does this by stressing the need, once again, to see recovery as something that can and should be understood in a self-determined, and presumably subjective, way as opposed to an objective and external way.

This description[9] is strongly connected to the criterion of functionality and it makes a link between functioning and self-help approaches to fostering recovery. This is clearly a way of saying that functionality is pre-eminently important. The issue here, it seems to me (and will be addressed later in the thesis), is the question of responsibility. How much should the individual be held responsible for their own health and how much should others and the psychiatric service be held responsible for those who do not appear to recover? The description seems to side-step those difficulties and perhaps that reflects the reality that this description makes a number of assumptions about individual capability being very high in terms of facilitating recovery. Part 3 of this thesis will attempt to answer some of these questions. The description, like the Curtis (1998) description, strongly assumes the individual is responsible for their own health by a "new and valued sense of integrity and purpose within and beyond the limits of disability" (p. 18).

This description essentially focuses – though implicitly – on the functioning criterion. It tends, in a muddled way, to mix that functioning criterion with how the client can foster their own recovery.

The final description that predates all of these previous descriptions is by Anthony[10] (1993a, p. 2) and is arguably the formulation that has influenced many of these subsequent descriptions (including that of the Mental Health Commission).

Description 4 (Anthony)

> Recovery, as we currently understand it, means growing beyond the catastrophe of mental illness and developing new meaning and purpose in one's life. It means taking charge of one's life even if one cannot take complete charge of one's symptoms. Much of the chronicity that is thought to be a part of people's mental illness may be due to the way the mental health system and society treat people with severe mental illness. Contributing to

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[9] Other work by Deegan also emphasises the importance of functioning, see Deegan (1996)

[10] Anthony (1993b) has written more extensively about the nature of recovery from mental illness.

people's chronicity are factors such as stigma, lowered social status, restrictions on choice and self-determination, the lack or partial lack of rehabilitation opportunities, and low staff expectations. Drastic system changes are needed if we wish to support people's recovery, rather than hinder people's recovery (Anthony, 1993a, p. 2).

This description can be seen to contain four main propositions:

1. Recovery involves moving beyond illness;
2. Recovery involves taking charge of one's life even if one cannot take complete charge of one's symptoms;
3. The way psychiatric services and society treat people with a mental illness is a barrier to recovery;
4. Psychiatric Services need to change to support rather than hinder people's recovery.

The four propositions present a mixed bag in terms of recovery criteria and ways of fostering recovery. The first two propositions are closely aligned to the recovery criteria. In the first proposition, recovery is achieved through "moving beyond illness", presumably both in the sense of functioning and symptoms.

The idea that recovery involves taking charge of one's life in Proposition 2 connects with propositions from other descriptions (particularly the idea from the Mental Health Commission of everyone's journey being unique). Taking charge of one's own journey as an assertive actor rather than a passive recipient of care seems an important ingredient to facilitating recovery. Anthony does not suggest one will necessarily have "complete control of one's symptoms". On the face of it, this might seem to reject the symptom criterion, but I think he is simply saying there is more to recovery than symptom reduction. I would agree with Anthony's assertion that clients need to take control of their life, but this can be seen as meeting the functionality criterion, though perhaps not in ways professionals would usually indicate.

Propositions 3 and 4 are concerned with barriers to achieving recovery and appear to place greater responsibility for recovery outside of the individual than either the Curtis (1998) or Deegan (1997) descriptions provided. The notion that responsibility sits with the individual or with psychiatric services in an absolute sense, as opposed to being seen more accurately as shared between the two is something that will be re-examined in subsequent parts of the thesis.

This discussion indicates there are a number of different descriptions of recovery that can broadly be understood as coming from the recovery approach perspective. From that perspective, clients are seen as needing to take responsibility for their own health and hence for fostering their own recovery. The emphasis in this approach is upon client self determination and autonomy. There are important points of convergence, but there are also important points of divergence between these descriptions. Those points of convergence include the idea that recovery involves an individual journey (though exactly what the journey involves differs); that those who have been unwell need to take some responsibility for their illness; and that recovery needs to be self determined rather than professionally determined. The points of difference between the descriptions offered here are the role of psychiatric services in recovery and who is responsible for recovery, both factors concerned not with the criteria for determining whether recovery has occurred, but with ways of fostering recovery.

The most important common feature of these four recovery approach descriptions is that recovery is seen as being about increasing client self determination, self responsibility and self awareness. These terms can be seen as elements of the functionality which is a criterion of recovery. There is indeed a general focus and emphasis in these descriptions on functionality, usually in a non-explicit way. The existence of so many descriptions makes it difficult to create a description that everyone can accept. However, the criteria of symptoms and functionality can still stand, even if what clients understand by functionality and symptoms is more personal[11] than that which professionals understand.

Problems with Professional and Client Perspectives in Isolation

Considered by themselves, client and professional perspectives each have possession of a partial truth but fail to provide a comprehensive account of the recovery criteria. Both client and professional perspectives have problems when considered in isolation.

The client perspective tends to be subjective in that what one client considers necessary for living well or coming to terms with their illness, another does

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[11] Ralph (2000) in discussing the personal factors for recovery thinks that four dimensions are present: internal factors, self managed care, external factors and empowerment. All of these four dimensions can be seen in the four descriptions discussed.

not. This is not in itself a problem, but there are implications that are problematic. One of these is that client subjectivity extends to using particular terms for understanding recovery that makes communication with others problematic. Since such personal criteria are being used to understand recovery from the client perspective, any outcome-based research becomes difficult in that such research will need to use standardised outcome measures where there are agreed definitions of terms. Client approaches have consequently found it difficult to produce evidence that the recovery approach is working. This lack of evidence is particularly problematic in psychiatric services where there is a growing emphasis upon evidence-based practice. The recovery approach as the dominant client perspective has tended to lack practical measures of its success in bringing about recovery. This has become a problem because of the muddle that the various recovery descriptions have created, since they fail to distinguish recovery criteria from ways of fostering recovery. There is also a disproportionate focus upon functionality and also the problem of clients communicating to others using different terms to report their functioning experiences.

Professional perspectives also have problems. They tend to downgrade the significance of the experience of the client and see the objective assessment and diagnosis of disorders as central. There is a focus on symptoms as specified in the main classification systems which often fails to appreciate the very personal response individual clients may have to their illness. There is often little focus (compared with the focus upon symptoms) on the clients' functioning in any holistic sense, except for those clients actually involved in a formal rehabilitation service. Even when there is a focus on functioning, it tends to be the functioning specified in the main psychiatric classificatory systems. While it tends to lend itself to standardised assessments, such an approach misses the unique experience of the individual client.

The purist approaches to fostering recovery which stress a particular professional or client perspective in isolation, have deservedly fallen from favour[12]. As we will find in Chapter 4, this has led to a stress on eclectic procedures based on principles for decision-making in psychiatric services.

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[12] In the same way that the 'purist' professional approaches to the various health domains have also fallen from favour.

Summary

This chapter has argued that the best way of understanding the concept of recovery is by seeing it as being fundamentally about improvement in the recovery criteria of symptoms and functioning for someone with a mental illness. However, it is important to acknowledge that professionals and clients have differing perspectives on the recovery criteria. Professionals tend to emphasise improvements in symptoms, whereas clients emphasise improvements in functioning. These criteria for recovery need to be differentiated from ways of fostering recovery. Historically, there has been an emphasis upon professional approaches to fostering recovery, which has recently changed to a client-based method in the recovery approach. There is a strong case made for seeing recovery as a process rather than as an end point along the illness-health continuum.

The next chapter will clarify some of the key terms used in psychiatric services and indicate the need to have a changing emphasis in the use of those terms.

CHAPTER 3

Conceptual Basis of Psychiatric Services: The Need for a Changing Emphasis

This chapter will discuss the conceptual foundations for psychiatric services that are most consistent with a pluralistic approach to facilitating recovery. Such a discussion will provide a basis for a pluralistic approach to fostering recovery developed in Part 3. This chapter will indicate the current conceptual foundations for psychiatric services, the problems with these concepts, and how these foundations need to have a changed emphasis if we want a pluralistic approach to facilitating recovery.

Section One is an account of the current conceptual basis of psychiatric services and an indication of the problems with these concepts. Section Two will indicate the ways in which this conceptual basis needs to change to be consistent with pluralistic approaches. Section Three will discuss the conceptual understanding of the mind-body problem that is most consistent with a pluralistic approach to facilitating recovery.

Section One: Current Conceptual Basis of Psychiatric Services and Their Problems

It is my contention that conceptually, current psychiatric services are based on the notion of mental disorder and that the distinction between mental disorder and mental illness is not fully developed or appreciated within those services. In order to appreciate this distinction I will assume that there are mental disorders from which it is possible to recover.[1]

These distinctions are discussed later, but briefly mental disorder is a 'categorical concept' whereas mental illness is a 'continuum concept' that is concerned with someone's response to mental disorder. A concept is called 'categorical' if membership of that category depends on a certain threshold being reached so that membership is all or nothing. In contrast, membership of a 'continuum concept' is a matter of degree. This focus upon mental disorder has a clear historical

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[1] Szasz (1961) argues that mental illness does not exist and that mental illness is due to people misunderstanding social rules. However, Szasz fails to distinguish between mental disorder and mental illness and his ideas seem to be a product of the 1960s, that is, part of a temporary fashion. There is a

origin (discussed in Chapter 1) in that psychiatrists wanted the same kind of exactitude in diagnosis and treatment as that available in physical medicine, and emphasising mental disorder was seen as the way to achieve that. At various historical points this exactitude has seemed to be best served by either biological or psychological approaches. The focus upon mental disorder has been strengthened by the categorical approach to classification in the two main psychiatric classification systems[2]. This strengthening has been the result of an increasing number of disorders being recognised along with their associated criteria.

Unfortunately, the increasing number of mental disorders with their associated criteria has led to the adoption of a crisis model of care. That is, it is the presentation of these disorders in a crisis state that has become the focus of psychiatric services, even though most of the clients of psychiatric services (at any particular time) are not in crisis. This focus on crisis is due to the increasing numbers of people becoming ill and the way psychiatric services have consequently taken the role of treating and caring for those most seriously ill, which in practice means the critically ill.

The Ministry of Health's Mental Health Act (1992) definition captures the focus that psychiatric services have on mental disorder in a crisis. This definition of mental disorder is arguably the most familiar definition and probably the most widely used. Mental disorder is defined as:

> An abnormal state of mind (whether continuous or intermittent) characterised by delusions or by disorders of mood or perception or volition or cognition, of such a degree that it: (a) poses a serious danger to the health or safety of that person or of others; or (b) seriously diminishes the capacity of that person to take care of himself or herself (p. 31).

Such a definition focuses upon the iconic crisis notions of risk to self (through suicide, vulnerability or deliberate self harm) and others, and misses or ignores the many other risks that are involved in client recovery from mental illness. I am

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general agreement today that mental disorder does exist and that it is important to distinguish illness from disorder.

[2] By main classificatory systems I refer to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorder* (1994a) and the World Health Organisation's *International Classification of Disease* (1992)

referring to such risks as not receiving treatment quickly enough, the side effects of medication, becoming dependent on psychiatric services and so on.

As will be discussed in Part 2 of this thesis, psychiatric services adopt a 'legislative imperative' in that services designed for people who are critically unwell and in need of the Mental Health Act are applied to all clients *just in case* they subsequently need the Act. Conceptually, the central problem with this arrangement is that while the Mental Health Act definition of mental disorder is agnostic about the cause of mental disorder, it does tend to move responsibility for recovery towards the psychiatric professionals and away from the client. In other words, it may allow for different types of professional intervention, but it tends to limit the client's attempt to improve their own health, which is a central component of a pluralistic approach to facilitating recovery. To make sense of how the focus on mental disorder ignores or obscures attention to mental illness, it is necessary to show how these terms are different and how they relate to the associated term of mental dysfunction.

The concepts of illness, disorder[3] and dysfunction are often used interchangeably. This is unfortunate since they are not synonyms either in a physical or mental context. These three concepts mean different things. They also have a different relationship to the concept of recovery understood in the pluralistic approach to fostering recovery. These three terms (illness, disorder, dysfunction) are related to both mental health and to the notion of recovery. These connections will be explored in Sections One and Two.

Disorder and Illness

Central to this thesis is the distinction between mental disorder and mental illness[4]. Borrowing from Boorse's (1975) paper "On the Distinction between Disease[5] and Illness" helps to show what these differences are. Boorse (1976) defines disorder as:

> a type of internal state of the organism which: (i) interferes with the
> performance of some natural function- i.e. some species' typical

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[3] Disease and disorder should be seen as interchangeable terms with disorder gaining ground in psychiatric practice. Disease is used in the *International Classification of Diseases*, whereas disorder is used in the *Diagnostic and Statistical Manual of Mental Disorder.*

[4] Physical disorder can similarly involve a physical illness in response to that disorder. However, unlike physical illness, mental illness involves using the same functions (i.e. thinking, feeling, judgement etc.) as the disorder which gave rise to it.

[5] Boorse prefers the term 'disease', but for consistency I use the term 'disorder'.

contribution to survival and reproduction – characteristic of the

organism's age; and (ii) is not simply in the nature of the species, i.e.

is either atypical of the species or, if typical, mainly due to

environmental causes (p. 62-63).

For Boorse, disorder is value free and factual, whereas there is always something undesirable about illness which is about values. Illness is a concept, moreover, whose criteria are highly subjective. Boorse (1975) says that "a disease is an illness only if it is serious enough to be incapacitating and therefore is: (i) undesirable for its bearer; (ii) a title to special treatment; and (iii) a valid excuse for normally criticisable behaviour" (p. 15). He goes on to indicate some particular difficulties with applying these criteria in mental health, but that does not stop him from trying. The problem for Boorse (as I will show in the next section on mental health) is that he sees disorder as value free and factual, and hence contrasts this with the subjective illness concept. Boorse's main problem is that no mental notions are value free since there is inescapably a subjective dimension to all mental notions and this applies equally in the context of both mental disorder and mental illness.

The three criteria that Boorse gives for differentiating disorder from illness would seem to apply not only to biological but also to mental phenomena. The central point of distinction, however, is one that Boorse fails to mention or acknowledge: namely the categorical nature of disorder and the continuum nature of illness. As already indicated, mental disorder relies upon a categorical distinction between various mental disorders (and between having and not having a disorder) based on discrete criteria, that creates threshold boundaries. Mental illness, in contrast, is a response to disorder and is necessarily a matter of degree[6].

The distinction between illness and disorder is not represented in the recent history of psychiatric care and treatment, where the emphasis has been on disorder. The psychiatric employment of the notion of mental disorder can be seen as an attempt to find and identify objective clusters of symptoms indicative of a currently viewed disorder process where the disorder process is to be understood in functional terms[7]. Since the birth of modern approaches in the eighteenth century, psychiatric

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[6] It might be asked whether illness can exist without disorder? I think that illness can at some point exist even though the original disorder has gone; but there will always be a need for there to have been a disorder at some point to trigger the illness experience.

[7] There is a difference between the validity and reliability of mental disorders as discussed by Read et al (2004). Reliability is concerned with the ability to agree consistently on the criteria for mental

care has been mostly concerned with diagnosing and treating particular disorders. This approach culminated in the clinical-expert ethos where the expertise of the clinician was valued over everything else. The problem with the disorder-based approach is that it stresses the responsibility of the professional in their ability to use a categorical classification system and ignores (or views as unimportant) the responsibility of the client. The disorder-based approach, since it is based on a categorical understanding of disorder, does not fit into the experiential sense of a continuum. The notion of mental illness gains in importance over time since the client's attitudes and expectations towards disorder become more central to the possibility of recovery. While it is important to appreciate the continuum nature of illness, it is true that in ordinary conversation we sometimes use the notion in a categorical way when we say of someone that they are predominantly healthy or ill.

Boorse is committed to a categorical difference between disorder and health since any deviation from a norm (in the sense of species specific functioning) moves that person from health to disorder. This position appears to have a number of problems, but these are only problems when we fail to distinguish between disorder and illness, since disorder in current psychiatric practice is a categorical concept whereas illness can be considered a continuum concept.

What is Mental Health?

My aim in this section is to show that mental health is an evaluative concept, best understood as being something that people subjectively determine for themselves but that has an objective basis in mental dysfunction which can be assessed by others. Mental health has been extensively defined but without any apparent consensus.[8] There appears to be a personal dimension in people's views of mental health that makes consensus unlikely even if it were desirable. If agreement is to be achieved, however, it will need to address this personal component. .

One of the most important contributions to the debate has been from Boorse (1976). In this paper, he argues against three commonly used ways of making sense

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disorders. Validity is centrally concerned with whether those disorders actually exist. It is possible that the current classification system has high reliability and low validity with regards mental disorder. However this thesis assumes the notion of mental disorder has some validity (although some mental disorders may have more validity than others).

[8] "Health is a dynamic state of complete physical, mental and social well being, and not merely the absence of disease or infirmity" (World Health Organisation 1998). This definition is one of the most well known, but flawed, definitions.

of mental health: 1) Affirmations of value (that is, identifying health with what we value); 2) Abstraction from established diagnostic classes (that is, indicating what health is by showing which disorders it is not); and 3) Social judgements of behaviour (that is, how people judge other people's behaviour as healthy). Boorse's argument is strong and convincing against these approaches. However, his own approach relies upon seeing health in objective ways, in that it assumes that it is possible to make statements about health that are independent of personal experiences. According to Boorse, "An organism is healthy at any moment in proportion as it is not diseased" (p. 62). In what follows, I outline Boorse's position in more detail and then indicate some problems with it.

Boorse sees health as the absence of disorder as already indicated in his definition of disorder. He believes the implications of his definition of disorder are that disorder should be seen as value free in that it is a matter of fact whether a disorder is present. However, as Boorse's own argument indicates, it is impossible for this to be value free.

Boorse attempts to make a case for health as an objective concept but in making his argument he cannot help but use evaluative terms that are not objective. For example, he says "One can sometimes infer internal malfunction immediately from biologically *incompetent* behaviour…. Even some psychotic people, as well as the great mass of those with neuroses and character disorders, function *successfully* at the minimal level required for basic biological goals" (1976, p. 76- 77, my italics).

Mental health is an evaluative[9] term that people use in ways that are meaningful to them personally. The evidence for the subjective nature of mental health is the diversity of views on what constitutes health. There has been a long tradition in psychiatry of emphasising the fact-value distinction[10]as a way of indicating the difference between discussing disorder and health. I think this distinction is helpful in that health is essentially something we value. However, while people subjectively determine what health means to them, there is a need to address the recovery criteria of symptoms and functioning which have a more objective basis.

There are objective criteria for determining whether someone has particular symptoms of mental disorder and whether they are functioning as individuals. The

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[9] There is a growing body of literature that supports the evaluative nature of mental health and psychiatric care. Fulford (1995a) has been a strong proponent of this view point.

real issue is how these factors relate to health. If someone has significant symptoms of disorder and problems with functioning, it would be difficult to consider them healthy. The objective criteria for determining mental health are based on the functioning of the individual since symptoms only become problematic when they affect functioning.

Part of Boorse's (1976, 1977) argument is connected to function (or dysfunction) in connection with mental health[11]. Boorse argues that when the internal state of an organism interferes with the natural functioning of that organism we can consider it to be dysfunctional, providing that the dysfunction is not common to the whole species. In this area he appears on stronger ground in making a case for an objective component. There surely is a connection between mental health and the presence of appropriate function. Function includes such mental activities as thinking, feeling, perception, volition, remembering, judgement and insight[12]. It is also referring to the many activity functions, such as walking or talking, which people perform as a result of these mental activities. If someone does not have these functions to any significant degree it would seem reasonable to say that they do not have good mental health and that they are dysfunctional. However, while some functions, such as walking, are objectively verifiable, others, such as thinking, have a more subjective component, in that other people can only assess them with the assistance of the client themselves. The client's experience of functioning is central, hence my contention that functionality uses both objective and subjective components. (This is reflected in the   recovery criteria discussed in Chapter 2.)

For the purposes of this thesis we can say that mental health is an evaluative concept based on the client's (subjective) experiences of functioning and the professional's (objective) assessment of that functioning[13].

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[10] See Fulford, Broome, Stanghellini and Thornton (2005) for an interesting analysis of why the fact–value distinction is so strong in psychiatry.

[11] Fulford (1995b) similarly makes a link between disturbances of functioning and the existence of disorder.

[12] See Wakefield (1992a, 1992b) for a useful functional account of mental disorder.

[13] It is worth emphasising that while mental health has this focus on functioning, mental disorder tends to emphasise the professional assessment of symptoms and functioning; while mental illness emphasises the client's assessment of functioning and symptoms.

Mental Disorder and Consensus in Psychiatric Services

Psychiatric services currently have a focus on mental disorder based on a categorical approach to diagnosis[14]. This categorical approach has a tendency to eliminate disagreements between professionals about what the client is experiencing in the interests of achieving consensus. In other words, the diagnostic classification system attempts to find a procedural consensus by firstly identifying certain signs and symptoms, then matching them with the criteria for particular disorders and hence confirming (or not) that a particular mental disorder is present. Consensus is very useful, particularly in crisis and acute presentations where actions to alleviate client distress are necessary. However, enforced consensus in later stages of a client's recovery may not be so helpful since the client may have a different perspective from that of the psychiatric professional. Part of the need to change current psychiatric services is to enable disagreements and differing perspectives to have more prominence. In Section Two I explain why it is important to include the client's perspective.

Section Two: Inclusion of Client Perspective

We have seen in Section One that current psychiatric services are conceptually bound to the notion of mental disorder. While mental disorder is a useful construct, the extreme focus on it by psychiatric services has tended to limit the usefulness of those services and some change of focus is necessary. That change of focus needs to have two components, both equally important if we are to move towards a pluralistic approach to fostering recovery. Firstly, we need to increase the emphasis on mental illness in contrast to disorder, while at the same time recognising that illness is connected to the pursuit of health. This should herald a new appreciation of the dynamic (that is the way the client moves back and forth along the illness-health continuum) and experiential nature of mental illness. Such experiences will probably increase the recovery consciousness of the client, that is their self-awareness of the experience of recovering[15]. Secondly, we need to acknowledge that the notion of mental disorder does have a place and utility in psychiatric services even though it should no longer be the dominant notion.

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[14] There are dimensional approaches to diagnosis, however, the categorical systems are clearly dominant at present within psychiatric services, hence my focus on them.
[15] I assume that consciousness exists, which writers such as Priest (1991) would reject.

Illness-Health Continuum

Increasing the focus on mental illness means an increased focus upon client subjectivity and personal experience. This increased focus on subjectivity means that clients come to value their own experiences more. There is a psychological connection between valuing and responsibility, in that we tend to take more responsibility for things we value. This is important if we want clients to take more responsibility for their own health, since the focus shifts from what the professional can do (in mental disorder) to what the client can do for themselves. Clients can take more responsibility for their own health when the continuum is stressed, since the numerous intermediate steps between illness and health become apparent, unlike the discrete boundary changes between the notions of disorder and health. This continuum is central to the gradual growth and development of recovery.

Putting Mental Disorder in its Place

Mental disorder – based on one of the categorical classification systems – has become the central focus and rationale for psychiatric services. Mental disorder is largely determined, or at least diagnosed, by psychiatric professionals. The role of the client can easily become quite passive and secondary to that of the psychiatric professional. Recovery under such circumstances can seem to be primarily about what the professional can do rather than about what the client can do. In large part because of this focus on the professional, psychiatric services tend to concentrate on the two criteria for recovery (from Chapter 2) namely the symptoms of mental disorder and, to a lesser extent, the client's ability to function from a professional perspective.

Recognising the distinction between mental disorder and mental illness is a first step towards changing the focus of psychiatric services to being more open to issues connected to the client's functioning and role in assisting with their own recovery.

Appreciating the role of the notion of mental disorder is connected with realising its strengths and weaknesses. According to most reliable evidence, there do seem to be mental disorders from which it is possible to recover. Diagnosing and treating mental disorder is an important part of recovery but not the whole story. A

greater focus on mental illness will enable the fuller story in terms of function and responsibility to be told. An ability to diagnose and treat mental disorder is particularly important in crisis and acute presentations, but it is also important in chronic disorders. In chronic mental disorders (and many mental disorders tend to have a chronic nature), there is a need for greater prominence to be given to mental illness with the emphasis on the client's response to the disorder. Since illness (unlike disorder) is a continuum-based concept and lies on the same continuum as mental health, "Putting mental disorder in its place" as a phrase comes to mean appreciating the strengths it has and also realising that greater prominence needs to be given to mental illness and the illness-health continuum.

The understanding of mental health, mental disorder and mental illness provided in this chapter is broadly pluralistic in that the various conceptions are combined in a way that allows the dominance of one approach at any moment, while still respecting the other approaches[16]. For example, in a crisis state, the realities of mental disorder are dominant, whereas when the client is actively recovering it is mental illness and health that become dominant.

Having clarified terms such as 'mental health', 'mental disorder' and 'mental illness' and their connection to recovery, it is necessary to indicate how 'the mental' connects to the brain, since there are some understandings of this relationship which are incompatible with the pluralistic approach to fostering recovery. Given that the mind-brain relationship is conceptually central to the nature of psychiatric services, some attention on this matter is important.

Section Three: Relationship between Mind and Brain

What is the relationship between the mind and brain? Mental disorder, mental illness and mental health all appeal to some notion of the 'mental'. This section will demonstrate how a pluralistic approach to fostering recovery requires an understanding of the relationship between the mind and the brain that fully respects the full range of internal events and experiences for the client.

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[16] I will have more to say later on pluralism, but at this point I will indicate the differences between pluralism and eclecticism. Pluralism, like eclecticism, accepts the need to respect differing approaches (i.e. the various professional approaches to the health domains and client self-help approaches) but, unlike eclecticism, sees the need for the decision-making to be based on professional and client judgement, rather than eclectic procedures.

It could be argued that the ontology of psychiatric services is particularly focused on the mind-body relationship. At different times in the history of psychiatric services there have been periods when either mind or body has been emphasised, often at the expense of the other. Some of the philosophical notions relating to the mind-body problem will be useful in this investigation.

There has been a movement based on identity theory[17] towards saying that psychological experiences (and events) are nothing but brain events and that a direct correspondence exists. Identity theory as a form of reductive materialism wants to collapse all psychological factors into physical processes. While such an approach allows for psychological factors, it ultimately wants to see them in physical terms. This approach says that while we may not yet understand exactly what those correspondences between physical and psychological processes are, one day we might. A more extreme physical theory holds that when neuroscience is sufficiently advanced we will be able to talk of eliminating certain psychological processes entirely. Eliminative materialism[18] holds that there is no need to use psychological language as a form of explanation.

From the psychological perspective, there is an approach which sees mental phenomena as ineffable, mysterious and perplexing. This approach is based on the notion of phenomenological qualia[19] and is essentially Cartesian with an emphasis upon the mental as somehow distinct from the brain substratum. Such an approach tends to emphasise phenomenologically unique experiences.

I think both eliminative materialism and phenomenological qualia-based approaches are impossible to integrate within a pluralistic conception of recovery. Eliminative materialism makes it impossible to work with psychological events and experiences as an explanatory level in itself; whereas qualia make it difficult to work with biological and chemical events in the brain. The identity theory approach could be used within a pluralistic account even though it is probably not a good model in that it makes such strong claims about the future reduction of psychological into

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[17] There is an extensive literature on identity theory. For example, two recent publications are Beall (2000) who discusses the nature of the identity theory from a philosophical perspective; and David (2001) who discusses the nature of identity theory and links this with the correspondence theory of truth.

[18] Eliminative materialism is probably best captured in the work of the Churchlands: Patricia Churchland (1986) discussing neurophilosophy and Paul Churchland (1979) the plasticity of the mind from a neurological perspective.

[19] There is an extensive literature on qualia. For example, Teller (1992) has discussed the importance of subjectivity and how it cannot be reduced to physical properties.

physical properties[20]. In attempting to foster recovery, we need to tread a middle road between the positions of eliminative materialism and qualia. A more integrative and reasonable position conceptually is one that embraces a form of mental emergence and commonsense functionalism.

Emergence theory is not a new theory. It has been around for at least sixty years as discussed by Ghaemi (2002). Such an approach rejects mind-brain identity, in that a mental state is not identical with a brain state. In this theory there is believed to be another level of explanation, which describes mental states that emerge from the brain state that forms its foundation. In such an approach, psychological experiences and events cannot be reduced to biological events and chemical events and so on. There is something about psychological events and experiences that is not explainable in the biological understanding and description. At a conceptual level, the emergent properties of the mental, such as thinking, feeling, judgement and the like, are more than the sum of the respective parts that have combined to make them. For example, while the mind may be dependant on neurochemicals acting upon the neurons within the cellular structure of the brain, to understand the mental still requires a different level of explanation from that offered by either chemistry or biology.

Such an account does mean we can retain a materialistic understanding and explanation of the brain while still providing a psychological explanation in its own terms for psychological experiences and events. Emergence theory underlies the essential nature of a psychological theory of description in a way that the identity theory does not.

There are many schools of thought with regards the mind-body relationship. The approach most compatible with both an emergent theory of mind and with pluralistic accounts of recovery is that offered by functionalism. There are many views on functionalism and therefore I will be assuming a form of common-sense functionalism[21] for the purposes of this section.

Functionalism is an approach to the philosophy of mind in which mental states are specified in connection with their causal role in relation to stimuli, behaviour and other mental states but it remains agnostic about what those internal processes and events are. The defining characteristic of common-sense functionalism

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[20] Olsen (2000) offers an analysis of why the identity theory of mind should not be used as the basis for understanding mental disorder.

[21] This view is represented in the work of Braddon-Mitchell & Jackson (1996)

is that the relations between different mental states, and between them and perception and action is known as a matter of common-sense.

Functionalism holds to the view that mental states are internal states within us and that these internal states are the causes of behaviour. Functionalists broadly agree with the position that there are input events that cause mental states in people; that there are output events which are the behaviours caused by mental states; and that there are internal events which describe the internal interactions between those mental states. Functionalism provides a means of conceiving the way the mind works, which can usefully provide a mechanism for explaining the disruption that is mental disorder.

Coupled with emergence theory, this common-sense functionalism can provide a conceptual basis for a pluralistic conception of recovery that circumvents the pitfalls of either extreme physical or extreme psychological approaches to dealing with the mind–body problem. While this account does not discuss at length the mind-body problem, it has certain implications for the nature of the mind-body relationship. There is a psychological level of explanation that is important for psychiatric services, and the concepts involved are not reducible to the physical, but the psychological does act upon the physical. This is consistent with taking both psychotherapy and psychopharmacology seriously.

Summary

This chapter has clarified the concepts of mental health, mental disorder, mental illness and mental dysfunction indicating that, while related, they are best viewed separately as different concepts. It has shown that current psychiatric services are disorder-focused and indicated that there are a number of problems associated with this when dealing with recovery. In particular, there is the problem of accounting for the range of individual experiences within a categorical disorder-based approach (which will become clearer in subsequent chapters). The solution indicated is to change the emphasis within psychiatric services to include a greater prominence for mental illness. Mental illness, unlike mental disorder, is continuum-based and connects to the notion of mental health along the illness-health continuum.

Finally, the single most significant conceptual issue in psychiatric services is the mind–body problem and the tendency, given psychiatry's history, of lurching towards either physical or psychological poles of that problem. A case has been made

for a broader appreciation, based on emergence theory and functionalism, which prevents a lurch towards either extreme.

The next chapter will explore the current ethos of psychiatric services focused on procedures where mental disorder is the consensus-building device used to make decisions about care and treatment.

CHAPTER 4

The Pervasiveness of the Procedural Ethos

The ethos of psychiatric services has changed a number of times historically, most recently from the clinical-expert to the procedural. This procedural ethos will be discussed in this chapter. As discussed in Chapter 2, even though the nominal philosophy of psychiatric services is meant to be based on recovery, according to the last published plan for psychiatric services in the Ministry of Health's *Te Tahuhu* (2005), the way in which recovery is now facilitated is based on eclecticism, underpinned by the procedural ethos, which is due to the eclectic procedures being reified.

Eclecticism is a way of combining the different domains of health (i.e. biological, psychological and social) in a procedural manner during the course of the client's treatment. The biopsychosocial model best exemplifies the eclectic approach. This approach, which is traditional within psychiatric services, provides a way of making decisions based on procedures that give equal weight to different domains at all stages. In this thesis I argue for a pluralistic approach to facilitating recovery which is contrasted with an eclectic approach. Pluralism also accepts the need to work with all the health domains, but, unlike eclecticism, does not hold the domains as equally important at all stages of the client's treatment. Pluralistic approaches accept that decisions cannot be left to procedures, and instead other decision-making approaches will be needed to determine which should be the dominant domain at any specific moment.

Eclecticism is very widespread within psychiatric services. Interestingly, although an ethos can have a major impact on services, it has received little attention from ethicists, bio-ethicists and philosophers (in the Anglo-American tradition), at least in terms of the ethos of psychiatric services. This is strange since an ethos refers to the characteristic spirit and beliefs of a community or society, which can include, but is not limited to, its ethics. An ethos is, in a sense, the climate in which ethics lives.[1]

The procedural ethos appears to be quite a general philosophy, which has come to pervade much of the public service in health and education both in New

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[1] See Jonsen (1990) for a sympathetic treatment of the importance of ethos. See Illich (1976) for a critique of the clinical-expert ethos and for indicating the problem with procedures and the need to move the recovery of health to centre stage.

Zealand and overseas. This procedural ethos is underpinned by the fundamental liberal views within our society, characterised by a respect for individual choices in that the state agrees not to favour one conception of the good life over another. In the context of psychiatric services, this fundamental liberal approach is given contextual meaning through the main intellectual tools and approaches also having a procedural focus. The psychiatric classification systems, such as the American Psychiatric Association's (*DSM,* 1994a) and the eclecticism based on the biopsychosocial model are procedural both in intent and in the way they are used. So, for example, in working with someone who has schizophrenia, the *DSM* provides biological, psychological and social criteria as a procedure for determining whether someone has the categorical disorder of schizophrenia. The biopsychosocial model provides the broad procedures (in terms of respecting all three health domains) for determining how those criteria for schizophrenia should be used. These procedures are essentially concerned with rules based on symptoms and function, while the rules rest on a number of moral principles. There appear to be a combination of principles, mainly autonomy, beneficence and justice, which will be discussed later.

Procedures are necessary for many aspects of life and my concern is not with isolated, specific, localised procedures but with the ethos that reifies procedural understanding over everything else. The argument in this chapter is three-fold: in Section One it is that a procedural ethos has become the *de facto* philosophy of psychiatric services; in Section Two it is that the procedural ethos in psychiatric services has a particular form characterised by rules and specific principles in relation to mental disorder; in Section Three it is that this procedural ethos is underpinned by a reliance on an eclectic approach to facilitating recovery based on the biopsychosocial model and the classificatory systems rather than a pluralistic approach.

Section One: Procedural Ethos as the *De Facto* Philosophy

There are a number of factors that have contributed to the development of the procedural ethos as the *de facto* philosophy within psychiatric services. These factors have included broad societal changes in which authority figures have become increasingly challenged in their roles. This has led to the end of the clinical-expert ethos. The main single factor, however, in the development of the procedural ethos has been the inability to find consensus in most ethical and clinical matters within

psychiatric services and a consequent need to find procedures that can command that consensus and that work[2].

There has certainly been increasing attention paid to finding a framework for reaching decisions that everyone can agree to use within psychiatric services. In previous times there has been more societal consensus around values that informed clinical decision-making. The mostly Christian value assumptions of the Victorian period have disappeared, together with any substantive ethical theory such as utilitarianism or Kantianism that can replace those values and have *all* the answers. With this lack of consensus has gone any chance of agreement around a particular ethical theory. However, while this may be true in the sense of a broad ethical belief system, there does appear to be some consensus around liberal values and, in particular, the importance of autonomy and self determination within Western societies[3]. These liberal values have influenced the kind of clinical decision-making that is made by psychiatric services but, as will be seen in Section Two, these liberal values have a unique flavour in psychiatric services. So, while there are a number of different clinical approaches within psychiatric services (e.g. biological, psychological and social) there has developed a belief that they should all be equally respected in that they are offering a unique perspective on the individual client's mental disorder. This approach is known as eclecticism. While none of the approaches is seen as offering a 'royal road' to the truth within psychiatric services, considered in isolation they are all thought to offer something important. However, while there are these differing approaches within psychiatric services, there is broad agreement that they should all be focusing upon mental disorder. This consensus around working with mental disorder should be contrasted with the lack of consensus around a substantive theory. This lack of consensus in an approach has led to the focus not on a substantive theory (whether clinical or ethical) but on a procedure for reaching decisions. The fact that there has developed a need to respect, rather than ignore, this diversity within society and psychiatric services more specifically is due to the liberal

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[2] It is worth commenting here on the issue of pragmatism. Part of the attraction of the procedural ethos has been that it appears to work. The problem for pragmatism is that the fact of something appearing to work does not, in itself, provide sufficient justification for doing it. A recent publication by David Brendel (2006) seems to make this mistake by arguing for a form of pragmatism in psychiatric services. As I see it, the missing justificatory element is the recovery ethos.

[3] While there is some debate about the foundations of liberalism, there is broad agreement, as discussed by Gray (1986) that freedom, particularly the positive freedom connected to self realisation, is fundamental to liberalism.

values which are central to our society and way of life. This respect for diversity within society and psychiatric services results in the view that the goods people pursue are best left to the individual. The state's role is seen as a minimal one of ensuring that in upholding the freedom and liberty of individuals it prevents individuals abusing that freedom through depriving others of their freedom[4]. The liberal values of self determination, autonomy and liberty provide the consensus societal view out of which ethical and clinical theories have emerged.

Liberal assumptions have given rise to procedures that have become reified over time. There are many examples but perhaps one of the most clear is that of discharge procedures. Psychiatric services have discharge procedures for both community and inpatient services. Originally these procedures were not particularly liberal in that only the expert could discharge clients, and many clients found it hard to be discharged. Increasing liberal tendencies in society led to more professionals being involved in the discharge process and, associated with that development, clients were much more able to self-discharge. The exceptions were clients who presented a risk to themselves or others, hence the need to have the psychiatrist involved in decisions about the discharge of clients from inpatient areas where risk was more obviously involved. Other professionals are less involved in discharge from inpatient areas and clients are discouraged from self-discharge. This apparently innocuous procedure has unfortunately become reified. Invariably, even when it inconveniences clients and staff, the psychiatrist is seen as being needed as a final decision-maker when there is good evidence that, under some circumstances, other professionals and clients can perform the role equally well. This is an example of a reified procedure, where reified procedures provide the foundation for the procedural ethos within psychiatric services.

At the same time as this proceduralisation was occurring, bioethics was emerging as a discipline. Bioethics has proceeded by developing considerable consensus around issues such as self determination and autonomy that are central to liberal values.[5] This consensus within bioethics needs to be contrasted with the

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[4] As Charlesworth (1993) has argued, the fact of living in a multicultural, diverse liberal society does not prevent authoritarian and paternalistic ethical practices. In psychiatric services this would be particularly true. Berlin (1969) provides a valuable contribution to the debate in distinguishing between two conceptions of liberty; namely a positive and negative sense. Someone may have negative liberty (freedom from) without necessarily having the positive sense (freedom to).

[5] Those consensus views around self determination are represented by Beauchamp and Childress (1994) and by Childress (1981,1982).

previous point in terms of the lack of consensus around particular clinical or ethical approaches, where societal consensus has not been achieved. While there have been voices at the margin who have disagreed with this emphasis within bioethics on autonomy they have not, until quite recently, gained much traction. For example, Pellegrino and Thomasma (1988) have argued that autonomy has become too central to practice and some balancing back towards beneficence is necessary. Moreno (1995) has provided a comprehensive account of how significant consensus has been for the development and formation of bioethics as a discipline. In a sense, consensus within bioethics provides another underpinning of the procedural ethos by indicating its liberal assumptions. Bioethics, particularly in the United States where it originated, has had a significant impact on clinical practice and hence the development of a procedural ethos. In bioethics there has been broad consensus about the fundamental liberal assumptions upon which the discipline rests. However, in attempting to implement those assumptions practically, there is a need to use particular procedural tools such as, for example, consent forms. Over time, many of these procedures, such as the use of consent forms, have almost floated free of the original liberal assumptions that gave rise to them and in so doing have contributed to the procedural ethos.

This combination of eclectic procedures (on how to identify mental disorder and treat it) and liberal values with a decreasing emphasis upon the role of the expert, have culminated in a *de facto* philosophy of psychiatric services where procedures have become reified. Reification refers to the way in which procedures over time become an end in themselves rather than a means to an end.

Taken together, these factors have contributed to the development of the procedural ethos within psychiatric services. That ethos is not unique to psychiatric services but within psychiatric services it does have a unique presentation. It is this unique presentation we must consider next.

Section Two: *Nature and Style of the Procedural Ethos*

This section will discuss the nature of the procedural ethos generally and then indicate the style of the procedural ethos within psychiatric services, indicating the central role of the Mental Health Act. It will then show the types of procedures in psychiatric services and how these cumulatively produce a procedural ethos rather than a collection of procedures. The nature of the rules that underpin the procedures

already examined will be discussed, and it will be shown that these rules, in turn, are underpinned by principles. The 'four principles' approach offers the best way of understanding the way those principles work in psychiatric services by indicating the difference between theory and practice. In practice, the principle of justice has become dominant, while the principles of autonomy and beneficence have become the most widely used.

Nature of the Procedural Ethos

Before considering the unique qualities of the procedural ethos within psychiatric services it is important to consider the nature of the procedural ethos more generally.

A procedure is a "mode of conducting business; a series of actions" (*The Little Oxford Dictionary* 1986, p. 428). An ethos is "the characteristic spirit of community or people or system" (*The Little Oxford Dictionary*, 1986, p. 186). A procedural ethos can be thought of, therefore, as the spirit of a community characterised by its mode of conducting business in terms of a series of actions. This series of actions can be seen as rules, processes, protocols, standards and guidelines. A procedural ethos is characterised by the community's reliance on such activities for most or all of its defined purposes. There are three defining characteristics of the procedural ethos: firstly, a reliance upon rules and procedures for making decisions; secondly, a 'procedural creep' where more procedures are constantly created; and finally, other forms of decision-making become less valued. The paradigm case of rules is legal procedures. The difference is that, while broadly all legal matters are procedural, not all procedures are legal, since some are guidelines, protocols and policies.

A procedural ethos is not the same as individual, localised, specific procedures. Psychiatric services, like other large organisations, made up of many people, will always require specific procedures. A procedural ethos has arisen within the psychiatric context because of two overriding issues, as discussed in Section One: firstly, the need to generate ethical consensus when in a diverse society there are many different values; and secondly, the need to create consensus between competing views on the nature and cause of mental disorder. Additional contributing factors for the development of the procedural ethos have been the risk averse nature of modern

society, the need for experts to cover themselves against possible legal action and the importance of ensuring everyone is treated in the same way.

There are a number of distinctions that we need to make among procedures. Procedures can be informal or formal in nature. Formal procedures are those that are established through guidelines, protocols, formal standards and the like; informal procedures are custom and practice ways of doing things, rule of thumb approaches, which have not been written down but that still have considerable traditional influence and power. The roles of various professional groups, amongst which there is considerable overlap in psychiatric services, can often have a strong set of informal procedures around what they can and cannot do. When these are analysed they are often seen to be custom and practice rather than an established policy. Within a procedural ethos we might expect that there would be many informal procedures and that these would be competing with established formalised procedures. These informal procedures can become formalised over time. In a procedural ethos we would expect to see 'procedure creep', that is, a constant process of informal procedures being created in areas where there previously were no procedures and then an ongoing process of converting informal into formal procedures.

We also need to make a distinction between procedures as social and psychological products. Procedures are social products at one level, hence they can be seen as ways of assisting relationships in a diverse society to work better. It is no part of my task to provide a sociological account of the role of procedures. They are, however, also psychological products and any account of procedures needs to provide some understanding of their significance in psychological terms. There are three possible psychological purposes served by procedures. Firstly, they provide a vehicle and mechanism for identity formation. When procedures are a matter of choice, we choose the procedures that tell others (and ourselves) the sort of person we are or would like to be. Secondly, they provide structure and stability in the flux of life, which helps us to anchor our deepest beliefs and convictions. Finally, they assist with human relationships by providing a minimal requirement for our interactions with others. This final point can be seen to overlap with a developmental account of procedures.

A further refinement of seeing rules as psychological products is to view them in developmental terms within the individual. Since recovery is fundamentally a developmental process, it will be useful to consider rules and their connection to

moral development. Riesman (1950) has presented one way of considering the moral development of individuals. He has portrayed four moral types: 1) The tradition-directed individual and/or society; 2) The inner-directed individual and/or society; 3) The other-directed individual and /or society; and 4) The autonomous individual and /or society. The idea is that morality starts as a set of culturally defined goals and rules which are more or less external to the individual or imposed on him or inculcated as habits. These goals and habits become internalised; that is, the individual takes them over as his own and regulates his conduct in conformity with them by developing a conscience. It can be argued that a procedural ethos has a tendency to entrap those in that service into earlier forms of moral reasoning, as will be explained in the next chapter. The phrase 'banality of evil' was coined to explain how seemingly ordinary people could commit horrendous acts of evil during the Nazi period in Germany. On this reasoning, though in a very extreme form, it was because they were functioning in an earlier, more primitive, reasoning stage.

Having discussed the nature of the procedural ethos in quite general terms it is now necessary to show how the procedural ethos has a unique presentation within psychiatric services.

Style of the Procedural Ethos in Psychiatric Services

It can be argued that society as a whole has become more focused on procedural matters in the past few decades. More people are participating in the legal processes within society and this tendency extends to healthcare. Many legal issues impinge and impact on the delivery of healthcare: from public health legislation to the Privacy Act and legislation pertaining to who can prescribe and administer medication and so on. Even within the hospital environment, legislation around health and safety affects most aspects of the delivery of care. There are hundreds of legislative Acts that have some relevance to the running of healthcare. The psychiatric service shares all these societal and healthcare influences with regards to procedures and has one of its own which is unique. The Ministry of Health's Mental Health Act (1992) is the legislation that details the procedures involved in placing a client under the Act because of their mental state. Contrary to popular belief, the Act is rigorous and to meet the criteria necessary to trigger the Act involves meeting a number of checks and balances. Changes to the Ministry of Health's Mental Health Act in 1992 made the Act more 'consumer friendly' by building in more checks and balances than previous

Acts. Essentially, the Act can only be applied if someone poses a threat to themselves or others because of their mental state. If a client is under the Act, it means they can be treated or kept in hospital without their consent. This might appear to allow considerable latitude for interpretation by expert clinicians, however, due to the judicial oversight of the Act and its implementation, through common law practice, a particular understanding has arisen as to what constitutes "danger to oneself or others".

Again, contrary to popular belief, most clients of psychiatric services do not need or fall under the conditions of the Mental Health Act. Yet the rigor of the procedures involved in the administration of the Mental Health Act has been transferred over to all those other clients to some extent. Why should this be? It may at first sight appear a strange development that the procedures intended to safeguard the rights of clients who are deemed to be a risk to self or others can be transferred to the vast majority of clients who do not need the Act. I believe there are three main reasons for this "legislative imperative". Firstly, there is the view that all clients can potentially come to need the Act. In other words, while the majority of clients are not under the Act, the belief is that their mental state may change so that they will need it; so we have all the procedures in place *just in case* we need them. The major problem with this position is that relatively small numbers of clients who enter psychiatric services informally (i.e. not under the Act) go on to need the Act subsequently. Indeed, the numbers are only slightly higher than for the general public. This reason from potentiality appears therefore weak. The second reason is that society is risk averse and only focuses on psychiatric services through the media when something goes wrong[6]. What this means is that if we have procedures in place that can cover maximal risk, then by definition, they will cover minimal risk and hence reduce the possible interest from the media. The problem is that most clients in psychiatric services are minimal risk, whereas we have a system with procedures designed to cover clients who pose significant risk. This second reason provides an explanation for the dominance of the justice principle in psychiatric services. Client risk to others has become more central than client risk to self in psychiatric services. As a consequence, the justice principle has become dominant over the principle of beneficence. The final reason for the extension of the legislative imperative to all

clients in psychiatric services is the practical one, that the clinicians who work with the 'risky' clients are also the same clinicians (by and large) who work with clients who represent small risk. The practical procedures are simply transferred over from the one group to the other, since the same clinicians are involved.

    According to Beauchamp and Childress (1994) procedures are one variety of rules; other varieties include authority rules (which the previous clinical-expert ethos advocated) and substantive rules (to use Beauchamp and Childress' term) such as truth telling, confidentiality and fidelity.

    While I agree that we have these three varieties of rules, I disagree with their view that we resort to procedural rules when we run out of substantive or authority rules. I believe psychiatric services represent a special case (because of the mental health legislation) in that the procedural rules have become dominant over other forms of rule-giving because of this legislative imperative.

Types of Procedures in Psychiatric Services

    There are three broad types of formal procedures within psychiatric services. Firstly, there are legal procedures that, as already indicated, tend to provide the dominant framework for constructing procedures. There are numerous particular legislative areas that influence psychiatric and other mental health services, for instance: human rights legislation, the Privacy Act and the Criminal Justice Act. The Mental Health Act provides the legislative imperative. Secondly, administrative procedures are procedures not explicitly connected to clients. There are a number of these: staff-related, grievance, allocation, funding, etc. These processes are many and varied and on the increase. For example, there has been a noticeable increase in administrative procedures since the District Health Board framework was introduced in 2000. Finally there are client-related or clinical procedures, such as admission, keyworking, discharge, cultural processes, protocols for restraining clients and secluding clients, guidelines for the safe administration of medications, guidelines for assessment, diagnosis, prognosis, transfer of care, etc. A procedural ethos usually makes procedures the final arbiter through the reification of procedures. Additionally, there will be a huge informal procedural infrastructure, with most custom and practice rules being invisible except to those working or receiving treatment in a service.

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[6] Morrall (2002) believes that the media and society is right to be concerned about the dangerousness

Given the long historical period during which psychiatric services were asylum-based, it should come as no surprise that custom and practice rules are particularly strong and influential and indeed, one of the defining characteristics of the service[7]. It is also one of the reasons why psychiatric services have found it so difficult to change: change involves introducing new formal procedures and this often leaves the powerful informal structures untouched.

There is one possible argument against the idea that a procedural ethos is dominant within psychiatric services at the present time. It might be argued that while there are many procedures in current psychiatric services these do not add up to a procedural ethos. In other words, many procedures do not equal a procedural ethos. This criticism appears plausible but it misses the point. The procedural ethos is about far more than the sum total of procedures – all of which, considered in isolation, may be justified. There are four reasons why I think this criticism is wide of the mark. Firstly, a procedural ethos covers all areas involved in a service, both in the sense of formal procedures and informal procedures. For example, in the case of the restraint of clients, there are formal procedures specifying the numbers of staff needed and how they should do the restraint; there are, however, also informal procedures concerned with ensuring that the right gender balance is on duty or available on call. It is difficult to get a sense of all the informal custom and practice rules which exist in any given service. The sense of being all-pervading and everywhere is a key feature of a procedural ethos. Secondly, the attitude towards procedures is one of relying on them as a final arbiter, rather than holding a critical and discriminating perspective towards them. Thirdly, it may not (and probably is not) consciously apparent to most people that they are working in (receiving treatment in) a service characterised by a procedural ethos. People are often blind to the ethos within which they exist, seeing it as value free, objective and timeless. This invisibility of the procedural ethos makes it difficult to resist the socialisation of new staff or clients into the procedural ethos. Finally, the procedural ethos affects the culture of the service, not just the formalised procedures but also the mores and language of the service, which is much harder to define. In looking at psychiatric services, all these evidential factors are present pointing to an ethos as opposed to a collection of procedures.

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of people with some mental disorders.

[7] The asylums developed many custom and practice procedures as a way of coping with large numbers of clients and staff without resorting to formalised procedures.

The Nature of Rules

All the procedures found in psychiatric services rest on rules. This subsection examines what the nature of those rules is in the psychiatric context.

Clinical, administrative and legal procedures are all fundamentally rule-bound ways of organising activities, reaching decisions and agreeing on standards. There have been many ways of understanding and interpreting rules, for example there are descriptive and prescriptive ways. In a prescriptive sense, rules are essentially ways of specifying a particular course of action. A paradigm case is driving on the left hand side of the road. Without this rule there would be chaos. A detailed critique of the various approaches to rules will not be provided here, but a brief discussion of the views of Searle (1996) is relevant. Searle sets out a theory of social institutions based on three fundamental building blocks that contextualise the nature of rules within a social context. I have chosen to use Searle's approach because it illustrates the social construction of rules, which is central to understanding how rules are developed in the psychiatric context. The first building block, according to Searle, is the use by society of physical objects (natural or man made) to serve social functions. For example, a collection of bricks in a certain order is assigned the social function of being a hospital and gains significant social status from such a designation. Searle is careful to distinguish between objects that are assigned a function that is immediately obvious (e.g. a chair) and those that are not (e.g. money). Intention becomes critical to this differentiation. The second building block is the development of a set of rules with associated actions that make possible what Searle calls "institutional" facts derived from those social functions. So a particular collection of bricks may be termed a hospital, but there are constitutive rules that make it a hospital; namely that it admits people who are sick as determined by a suitably qualified person in order to help them. The third building block is that there has to be a mechanism by which the social functions and rules are able to derive recognition and acceptance. In other words the "hospital" only becomes a hospital when the social function and rules have achieved recognition and acceptance by a sufficiently wide number of people.

Searle's understanding of rules can be related to psychiatric services because psychiatric services, as a human service agency, is concerned with relationships in a way which is consistent with the social construction of rules.

The rules within psychiatric services are based on principles, and currently these principles reflect the dominance of the liberal consensus. Before considering these principles in more detail it will be helpful to comment briefly on the connection between procedures and principles.

Procedures, which are the dominant expression of rules in psychiatric services, are based on moral principles. While there have been a number of ways of making decisions using methods which rely upon some kind of procedure, this discussion will use the principle-based approach developed by Beauchamp and Childress (1994) for three main reasons. Firstly, it is very widely used within psychiatric services. Secondly, and perhaps most importantly, it highlights a problem common to all such approaches: namely the difference between theory and practice. While it certainly was not part of Beauchamp and Childress' intention to indicate the discrepancies between theory and practice, their approach, like all principle-based approaches, is vulnerable to this difference between the theoretical understanding of the ideas and their application in practice. Thirdly, it can help to show the way particular principles (namely justice) have become dominant within the procedural ethos.

The Four Principles

The rules that have been discussed within the procedural ethos of psychiatric services are based on a number of principles. While there are many ways of interpreting these principles[8], the framework provided by Beauchamp and Childress has become one of the most influential. Since its first edition in 1979, Beauchamp and Childress' book, *Principles of Biomedical Ethics,* has established itself as one of the most important books on healthcare ethics ever published. Indeed, so enormous has been its impact that it is often viewed uncritically as *the* approach to ethics in health situations. While there have been many factors contributing to the development of the procedural ethos (the dethroning of the expert; the proliferation of procedural approaches; the increasing legislative framework to modern society; and the

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[8] Gillon (1994) provides another approach to interpreting principles.

increasing need to find consensus in reaching decisions) Beauchamp and Childress's *Principles* has become the most widely known, understood and accepted principle-based framework within psychiatric services and, in that sense, a factor in the development of a procedural ethos within psychiatric services.

The four principles approach, as representative of principle approaches in general, will be shown by differentiating between their use in theory and practice.

The Four Principles Approach in Theory

Beauchamp and Childress lay out an approach to ethics in healthcare that is simple, elegant, eclectic and flexible, all of which ingredients have inevitably led to clinicians finding them attractive. The principles approach (the authors are reticent in their use of 'theory' to describe their endeavours) is based on what they term 'the common morality', by which they mean socially approved norms of human conduct. According to Beauchamp and Childress, the common morality exists before we are instructed in its relevant rules and regulations. They see their approach as representing a 'coherence' version of theory that is determined by considered judgements (based on the common morality) where there is interaction between theory and individual cases. They contrast such an approach, based on considered judgements, with deductive and inductive accounts. By deductive they mean approaches that move in a deductive fashion from rules to particular judgements. By inductive approaches they mean proceeding to justification based on individual cases. Casuistry is the pre-eminent example of this approach that was dominant during the clinical-expert ethos.

The four principles approach has four clusters of principles. These are 1) respect for autonomy (a group of norms respecting the decision-making capacities of autonomous persons); 2) non-maleficence (a group of norms avoiding the causation of harm); 3) beneficence (a group of norms for providing benefits and balancing benefits, risks and costs); and 4) justice (a group of norms for distributing benefits, risks and costs fairly). Historically, according to Beauchamp and Childress, beneficence and non-maleficence have been the dominant principles, whereas autonomy and justice have been neglected. Interestingly, the justice principle now appears to be a dominant principle within psychiatric services.

The four principles in the Beauchamp and Childress model are to be seen as *prima facie*, by which they mean that it is an obligation which should be fulfilled unless it conflicts on a particular occasion with an equal or stronger obligation. Two

other important components of their approach are the need to specify and balance principles. By 'specification' they mean the way we carefully indicate how a principle should be applied (as opposed to being an abstract principle). In doing this, we are exhorted to take into account efficiency, institutional rules, law and clientele acceptance. In other words, specification is about providing the context to the principle. For example, we might agree that clients should be given as much autonomy as possible but what that means will vary with the context. In an acute or crisis setting, autonomy promotion will mean something quite different from autonomy promotion in a rehabilitation context. By 'balancing' they mean a process of deliberative judgement in which we consider the relative weights of norms. They see balancing as useful for individual cases and specification as more useful for policy development. In their account, they have a special place for the virtues and see principles and virtues as being complementary. Indeed, they try to operationalise their principles by linking them to corresponding virtues. Part 3 will argue that Beauchamp and Childress have, so to speak, put the cart before the horse[9] and that it should be virtues that generate principles and not vice versa.

Four Principles Approach in Practice

Whatever the theoretical understanding of the four principles, in clinical practice these intended understandings and usages have been changed in subtle but important ways as they would be for any principle-based theoretical approach. The clinical realities of service provision in psychiatric services, like much of healthcare, has found the four principles approach congenial because of its apparent simplicity, user friendliness and its ease of application to the messy world of clinical practice. However, in using the four principles, important caveats in the original and intended use have been forgotten, misunderstood, ignored or misapplied. The skeletal structure of the four principles remains as a mantra that needs to be considered, but the notion of *prima facie,* as opposed to absolute, rules is often blurred or misapplied in practice, which means principles are often seen in an absolute sense (which makes balancing them superfluous). This is particularly important when discussing the recovery approach where there is a strong emphasis on rules, such as offering clients choices,

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[9] Beauchamp and Childress (1994) are not the only ones to put the cart before the horse in the way I have mentioned. The Mental Health Commission (2001, p.36) in discussing the philosophical

empowerment and self advocacy[10]. If these rules are seen as examples of the autonomy principle, it is easy to see how absolute commitments to these rules could be dangerous. For example, seeing choices and empowerment in absolute terms for critically unwell clients could result in someone with suicidal thoughts leaving an inpatient unit because that was their choice and allowing them to exercise that choice could be seen as empowerment.

Specification is poorly articulated in practice and is one of the reasons for the development of the procedural ethos through the creation of service specific policy. While Beauchamp and Childress' account of specification is somewhat vague, it is possible to see some clarity in their use of the term. The lack of adequate specification has resulted in institutional needs determining which principles will dominate. The lack of specification has also meant a growth in informal procedures based only loosely on principles. In the case of psychiatric services, procedural justice is the major specified principle, whereas in non-governmental organisations, autonomy has become the major specified principle.

Another practical reality in using a principle-based approach is the way balancing has come to be used in practice. In practice, the principles have assumed a hierarchy. In non-governmental organisations and private practice this has meant autonomy has become dominant over other principles. For example, many non-governmental organisations and private services, in order to keep the autonomy principle dominant, would transfer clients to psychiatric services if paternalism (through Mental Health Act legislation) were necessary. This means that while balancing of one principle against another may occur, the outcome is generally predictable. In psychiatric services justice is the dominant principle. This hierarchy finds its way into procedural policies and protocols that over time come to reflect this imbalance between the principles.

A further consequence of the dominance of the principle approach within psychiatric services is that professionals and clients do not always see themselves as applying the principle-based approach at all. The principle-based approach is often the invisible framework that is used to reach decisions (indeed much like the procedural

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foundations of recovery, assumes that there are only principle-based approaches, of the utilitarian and deontological variety. No mention is even made of virtues.

[10] While these activities are not, properly speaking, principles, they are related to the principle of autonomy. The Mental Health Commission (2001, p.25) lists a number of, what it terms, principles of recovery which are similar to the activities I have mentioned.

ethos itself).The reason for this is partly connected to the socialisation of professionals in the principle-based approach. Many of these professionals and clients might explicitly refer to another way of making decisions, but the ability of the principle-based approach to lend itself to consensus-forming decisions tends to be given greater weight.

Unintended Consequences of using the Four Principles

While principle-based approaches – like the four principles – do not see one principle as being more important than another in theory, practice would seem to be another matter. There are three unintended consequences of using a principle-based approach to make decisions. The first unintended consequence is that one principle tends to become dominant within particular services. Justice has become dominant within psychiatric services, while autonomy has become dominant within non-governmental organisations and private practice. The reason for this is that psychiatric services tend to deal with clients in a more severe state and hence the focus is on ensuring, ultimately, such clients do not pose a risk to society. A further reason is that overriding autonomy in society is generally broadly only permitted to prevent harm to others. Even J S Mill, one of the great architects of liberalism, did not consider self-harm a sufficient warrant.[11] While overriding autonomy is permitted within psychiatric services to prevent client self-harm, the focus by society on justice is reflected in the dominance of this principle within psychiatric services. Non-governmental organisations and private practice transfer disturbed clients to psychiatric services, which allows them to continue with autonomy as the dominant principle. The second unintended consequence is that autonomy and beneficence, while they are non-dominant principles within psychiatric services, are the most frequently used, which is reflected in policies and protocols. The third unintended consequence is that because autonomy and beneficence are the most frequently used principles, the so-called autonomy-paternalism split is often seen as the central issue in psychiatric services. However, as I will show in Part 3, there are better ways of

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[11] JS Mill (1991) in *On Liberty* discusses the 'harm principle' in which it is seen as unwarranted to force someone to do something for his or her own good. The harm principle is inherently vague however as a concept: How do we define it? Surely there are paternalistic interventions that are justified, for example forcing people to wear seat belts or placing fluoride in water? Mills' ultimate appeal to the harm principle makes it difficult to accept such paternalistic interventions

making decisions than relying on principles which see the autonomy-paternalism split as central.

The combination of liberal values and paternalism is, in its form of presentation, unique to psychiatric services. However, it is the legislative imperative which shows the uniqueness of the application of principles within psychiatric services. The legislative imperative is concerned with the way in which procedures designed to deal with clients under the Mental Health Act legislation are applied to other clients not under the Act. Clients under the Act tend to be in a crisis state and hence their mental disorder tends to be severe.

As the dominant principle it is the factor of procedural justice that requires more discussion within psychiatric services.

Procedural Justice

There are many models of justice[12]. One of the problems with the principle of justice, unlike the other principles, is that it tends to take on a political stamp and discussions often move away from particular clients to questions of political justice at a more abstract level[13]. While issues connected to distributive and reparative justice are important and play a role in psychiatric services, I would argue that it is procedural justice which is the most important way of understanding justice within psychiatric services.

Procedural justice concerns the fairness of the processes by which decisions are made. Fair treatment is often identified with those procedures that generate relevant, unbiased, accurate and consistent, reliable and valid information.

Procedures are fair if they are consistently applied. Firstly, like cases should receive like treatment[14]. Additionally, any distinctions should reflect genuine aspects of personal identity rather than extraneous features of the differentiating mechanism itself. Secondly, those carrying out the procedure should be impartial and neutral. Thirdly, those directly affected should have a say in the process (in a participative sense). This is particularly important for weaker parties whose voice may go unheard. Finally, the process needs to be transparent and decisions need to be reached through open procedures that are visible and not secret.

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[12] There is an extensive literature connected to procedural justice. However, mention will be made of Bone (2003) who indicates the difficulties of using contractarian theories of procedural fairness.
[13] Similar problems will be evident in our discussion of the 'psychiatric community' in Chapter 8

Procedural justice is enormously important for all procedures but particularly for that relatively small number of clients under the Mental Health Act. Unfortunately, what is procedural justice of a participative variety for clients under the Act, becomes something quite different when applied to the vast majority of clients who are not under the Act. There is evidence that procedures set up to work for clients under the Act are being applied to all clients *just in case.* 'Just in case' use of procedures is very widespread, from inappropriate use of holding orders to inappropriate use of threatened community treatment orders. For example, section 111 of the Mental Health Act (known as the nurses' holding power) has often inappropriately been prescribed in the case notes 'just in case' clients attempt to leave. In these cases, clients not meeting the threshold for the application of the Act are informed that the Act will be used if behaviours do not change or if there is a worsening in the client's presentation. It could be argued that this is a perversion of procedural justice and that it represents a lack of justice to the large majority of clients not under the Act.

While justice may be the dominant principle in psychiatric services, using principle-based approaches as the main vehicle for understanding recovery from mental illness is not helpful. Principle-based approaches have been widely critiqued, but in connection with recovery from mental illness in psychiatric services, the fact that it provides the underpinnings to the procedural ethos makes it particularly suspect.

Principle-based approaches have helped to create a combative approach to understanding differences between procedures, based on the dominance of autonomy within non-governmental organisations and private practice and procedures, based on the dominance of justice within psychiatric services. This has tended to entrench views and polarise positions along the autonomy-paternalism continuum and prevent the development of any sense of a common community. This is also because of the frequency with which the autonomy and beneficence principles are used for making procedures within psychiatric services, thus, once again emphasising the autonomy-paternalism split. As will be shown in Chapter 8, this lack of a common sense of community within the psychiatric and other mental health services is particularly problematic. Additionally, the principle-based approach has also contributed to the

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[14] Interestingly, Aristotle thought it equally important that unlike cases be treated in an unlike manner.

development of eclecticism within psychiatric services through the requirements of procedural justice for all health domains. That is, using the principle-based approach has meant, as a matter of justice, that health domains such as the biological, psychological and self-help approaches should all be seen as equally important for all occurrences along the illness-health continuum.

Applying the Justice Principle to Mental Disorder

The principles of justice, beneficence and autonomy, through the development of various procedures, have been applied to mental disorder (about which some consensus can be formed as discussed in Chapter 3) in modern psychiatric services. These principles can often be in conflict but when they are, invariably it is procedural justice that appears to be dominant within psychiatric services. The principles of autonomy and beneficence are the most widely used principles within psychiatric services. Justice, as a principle, is more complicated in the way in which it is applied. The legislative imperative has meant that the interests of the broader community are seen as being (on occasions) more important than the client's interests. However, perhaps the most significant sense in which justice as a principle is seen in psychiatric services is via the procedural eclecticism which wants to do justice to all the various intervention modalities, including client self-help, that can assist with mental illness. It is to this misapplication of the justice principle, as I see it, that we now turn.

Section Three: Eclecticism

The procedural ethos that has developed within psychiatric services is underpinned by a particular understanding of eclecticism. That eclecticism is based on the biopsychosocial model and the psychiatric classification system.

The eclecticism that has come to characterise psychiatric services is essentially due to a misguided belief that all the various health domains are equal and thus entitled, through the principle of justice, to be given equal consideration.

As discussed in Chapter 2, the form of eclecticism that has developed in psychiatric services is one that provides a procedure for facilitating recovery, based upon symptoms and functioning. As already indicated, it is unhelpful to have an eclectic approach to facilitating recovery. The reason that eclecticism can be unhelpful in psychiatric services is that eclecticism has tended to be based on the

biopsychosocial model[15]. This model has been briefly mentioned earlier but here I will provide a fuller account since it can be easily understood and described.

The biopsychosocial model developed in psychiatric services as a response to the lack of agreement within those services towards a particular approach. As was indicated in Chapter 1, during the clinical-expert ethos there were differing views between biologically and psychologically inclined experts as to the best way of dealing with psychiatric disorders. When it became evident that purist approaches from either a biological or psychological perspective were inadequate in treating mental disorder considered in isolation, greater attention was focused on other approaches.

The biopsychosocial model proposed that there were a number of domains that needed to be considered when addressing mental disorder: the biological, the psychological and the social. Arguably, the need to do justice to the other health domains was a strong motivator for those professionals committed to eclecticism. One of the key factors, as discussed by Ghaemi (2002), was the relationship between these domains. That is, they were to be seen as equally important. The other key component of the biopsychosocial model was that it was concerned with experts, not with the client helping himself or herself. In other words, it was concerned with an eclectic model of professional intervention.

However, it is important to note that recent attempts by psychiatric services to become recovery focused (in line with the Ministry of Health's National Mental Health Plan) have meant that client perspectives have been included, *but in an eclectic manner.* That is, the biopsychosocial model has been widened to include the client's perspective as another equal health domain.

The notion of the client's perspective is one which needs some clarification. Psychiatric services, with their focus upon mental disorder, have always wanted the client's perspective but for the purposes of matching symptoms to the criteria of various mental disorders. This sense of a client's perspective needs to be contrasted with the notion of the client's view of their situation and disorder beyond the simple

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[15] Eclecticism within psychiatric services came to prominence in particular through the work of Meyer (1948) which propounded a theoretical biopsychosocial approach, and through the work of Engel (1978) in which the model was applied. Eclecticism has therefore become linked with the biopsychosocial model. However, there are other possible approaches to eclecticism. The approach I am using here is one that sees client-determined and professionally determined approaches to fostering

requirements of matching a categorical classification system. Such a broader sense of client perspective includes a client view on 'symptoms' and 'functioning' as we saw in Chapter 2.

The psychiatric classification systems are concerned with describing the criteria for a number of discrete mental disorders. The history of the classification systems[16] coincides with the emergence of the biopsychosocial model with its eclectic assumptions. The classification systems, while agnostic about the causes of mental disorder, are essentially eclectic in that they do not stipulate which approach should be used to facilitate recovery. Indeed, the classificatory systems tend to assume a stress-vulnerability perspective[17] on the causes of mental disorder that is essentially agnostic about causes and relies on a multifactorial approach based on several health domains. The eclecticism of the main tools of psychiatric services tends to mean that there can be a level of consensus about the problems the client has, once the mental disorder has been identified. However, that consensus has come at a cost. That cost is a progressive lessening of respect for decision-making which is not based on eclectic procedures.

Summary

This chapter has presented an argument that a procedural ethos is currently the dominant spirit and way of working in psychiatric services, or, in other words, the *de facto* philosophy of psychiatric services. That procedural ethos is characterised by a reliance on rules activated through numerous protocols, standards, guidelines and policies. There is a distinction between procedures in a localised, specific sense and a procedural ethos, and specific procedures will always be required. It was argued that the procedural ethos was implicated in all activities within psychiatric services.

A case was made that, in psychiatric services, rules had taken a certain form because of the legislative imperative and the principle of justice had become dominant, though the principles of autonomy and beneficence were the most widely

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recovery as equally important, though in different ways. Professionally determined approaches can be equated to the biopsychosocial approach.

[16] The International Classification of Diseases (ICD) first included mental and behavioural diseases in 1938. The current ICD –10 was published in 1992. The first *Diagnostic and Statistical Manual of Mental Disorders (DSM)* was published in 1954 and the current *DSM IV* in 1994.

[17] The stress-vulnerability approach was originally presented in Zubin and Springs (1977) paper on schizophrenia. In this model everyone has a number of vulnerabilities, which, when combined with stresses can lead to mental disorder.

used principles underpinning procedures. Reference to the four principles approach showed that there was a distinction between the theoretical and practical applications of principle-based approaches. This distinction between the practical and theoretical understanding of a theory is important because the procedural ethos is a practical reality and hence the importance of the practical way a theory is used.

It was shown that underpinning the procedural ethos was a particular understanding of eclecticism, determined by the biopsychosocial model and the psychiatric classification systems that relied particularly on the justice principle.

The next chapter will present some practical examples of the problem with the procedural ethos within psychiatric services.

CHAPTER 5

The Problem with the Procedural Ethos

There are problems with adopting the procedural ethos if we want to assist clients to recover from their mental illness. There are conceptual difficulties – as we have seen – with the focus by psychiatric services upon mental disorder which have influenced the way in which psychiatric services have adopted an eclectic approach to fostering recovery as opposed to a pluralistic approach. Quite apart from these conceptual difficulties (which have been addressed in earlier chapters) there is a range of practical problems with the procedural ethos which make it unsuitable as a *de facto* philosophy of psychiatric services. It is these practical shortcomings which this chapter will address.

The following sections will all focus upon the practical problems involved in having a procedural ethos in psychiatric services for clients, professionals, psychiatric services themselves and the wider society. Section One will focus on clients of psychiatric services. Section Two will focus on psychiatric professionals. Section Three will consider the difficulties for psychiatric services themselves with the adoption of a procedural ethos. Section Four will consider the problems for the wider society. Finally, Section Five will consider general problems with the adoption of a procedural ethos. The focus on these five areas will show how profound the impact of the procedural ethos has been and they also represent the components of any pluralistic approach to understanding psychiatric services. Clients and psychiatric professionals are the groups most affected in the adoption of a procedural ethos, so the primary focus will be on these groups.

Section One: Effects of the Procedural Ethos on Clients of Psychiatric Services

The aim of this section is to show the effects of the procedural ethos on the clients of psychiatric services. These effects will be briefly listed before working systematically through them one by one. While there are a number of factors that affect clients of psychiatric services in response to a procedural ethos, fundamentally clients tend to assume less responsibility than is necessary for recovery which can, in turn, affect many other factors. One of these factors is trust, which is potentially jeopardised through the reliance on procedures rather than on therapeutic relationships, since procedures tend to focus on minimal expectations rather than

ideals. Additionally, there is the problem of admission to and discharge from psychiatric services, which is also affected by a procedural ethos. Also a procedural ethos tends to result in the client's voice being largely ignored because those working in psychiatric services create most procedures. Finally, the principles of justice and autonomy (which underpin the procedural ethos in, respectively, psychiatric and other mental health services) can be in conflict, both between psychiatric and other mental health services and within psychiatric services.

As previously shown, recovery involves clients assuming increasing levels of responsibility for their own health. A procedural ethos tends to limit the amount of responsibility clients can either exercise or adopt. The procedural ethos does this by encouraging and rewarding externalised decision-making. By externalised decision-making is meant that decisions are based on guidelines, recommended best practice, policy, protocols and evidence-based research. This is not to critique such methods of reaching decisions in themselves, only the uncritical reliance on them for making decisions. During the clinical-expert ethos, the responsibility for the recovery of the client lay with the expert. The procedural ethos has replaced this and, as a consequence, responsibility for the recovery of the client has shifted in large part to the procedures (in whatever form) currently in place within the service. By externalising decision-making in this way, the internalised responsibility that clients have for their own health is seemingly lessened. The problem is that while procedures can help a client recover, particularly in the early stages of an illness when the client is critically unwell, they can undermine a client's recovery by inhibiting or preventing the client from making decisions for themselves in areas which cannot be proceduralised easily. This occurs particularly with regard to personal issues, for example, the types of relationships the client wants with people, how to pick the right moment to re-enter the workforce and whether to join a support group. These sorts of decisions are hard to proceduralise. The danger is that a focus for recovery becomes those things which can be proceduralised easily, such as the order of using different types of medication, assessment of symptoms and the like, while the kinds of things that cannot be proceduralised (or at least not easily) are seen as less important. Recovery involves decisions in all these areas, both the easily and non-easily proceduralised. Even were good procedures to exist for these more personal issues, the danger might be that clients would come to rely upon them in an externalised sense and this would also undermine their assumption of responsibility.

Part of the problem is one of ownership. If clients base decisions on procedures that they have not created, they simply have no sense of ownership of them and therefore take little responsibility for using them. Those who work for psychiatric services have created most of the procedures within psychiatric services. Consequently, it is these psychiatric professionals who have the sense of ownership for these procedures, not the clients. Even when clients (or previous clients) have created procedures, other clients following them slavishly are still not assuming responsibility themselves. Copeland (1997) provides a detailed set of procedures for clients to identify their own healthy behaviours, early warning signs and wellness recovery plans, including crisis plans. The crisis plan for this programme is a form of advance directive indicating what the client wants for their care if they become ill in the future. While it is possible for clients to take responsibility for decisions based on external procedures, when those procedures exist within the context of a procedural ethos this becomes very difficult. The reason for this, as we saw in the last chapter, is that a procedural ethos is all encompassing, affecting both formal and informal procedures. In the case of procedures for advance directives, it is particularly difficult for clients to take responsibility, since there are many formal and informal procedures external to the client. Following a set procedure for writing an advance directive may have all the appearance and little of the substance of an advance directive[18]. From my own experience as a psychiatric professional, an example of this would be a client who is currently competent, who makes decisions based on advanced directive procedures and takes responsibility for their own future care if they become ill but who can not access the advance directives paperwork without professional oversight. I will leave aside problematic elements with the advance directive in psychiatry per se[19]. Instead, as currently practised, implementing an advanced directive procedure mostly becomes an exercise in deciding who should fill out forms. In many services, these advance directives need to be countersigned by the client's psychiatrist and key worker whether formally or informally. Part of the recovery journey for clients is to take more responsibility for their own health, though how much responsibility will vary from person to person. Some clients may always need some input from psychiatric professionals, some will not. In the case of procedures connected to

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[18] See Mental Health Commission (2002) for information on how the advance directive is meant to be used.

advance directives, it is likely to be the psychiatrist and key worker who have the sense of ownership and hence responsibility connected to the advance directive, rather than the client. My overall point here is not to critique the use of advance directives but to show how easily the procedural ethos can subvert a therapeutic objective. The advance directive is not necessarily bad, but its ability to assist the client is lessened by the way it is bureaucratised.

Trust is also potentially jeopardised by a procedural ethos. Clients need to trust that psychiatric professionals have their best interests at heart when they lessen their responsibility to assist a client to recover. As O'Neill (2002) has illustrated in her Kantian argument for the centrality of trust in healthcare over autonomy, in gaining increased autonomy we have lost some of the necessary trust that human agencies need in order to survive. This is because the understanding of autonomy has focused on the acquisition of rights as its prime purpose. This has undermined trust through two main outcomes. Firstly, clients have become focused on their rights over their responsibilities. This has contributed to the procedural ethos, as rights were translated into policy, protocol and legislation documents. The second outcome has been that psychiatric services and professionals have become more risk averse. As the list of client rights expanded, there was a corresponding professional and administrative industry designed to make sure professionals and services were not deemed negligent in ensuring those rights were provided. O'Neill (2002) believes that an understanding of autonomy entailing human obligation is the best way of ensuring trust reasserts its place in healthcare. In psychiatric services, trust is a vital component of the relationship between the psychiatric professional and the client. The reliance on procedures, as opposed to other considerations (such as personal or professional virtues) does potentially undermine this since it tends to represent an understanding of autonomy without the entailment of obligations. This development has occurred because, in focusing on the proceduralisation of rights, the corresponding responsibilities, whether of clients or professionals, have been somewhat overlooked. Obligations are essential for client recovery in mental health: clients need to assume a number of responsibilities along the recovery journey and professionals need to be able to trust that clients will indeed assume those responsibilities. For their part, clients need to be able to trust that professionals have their best interests at heart and

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[19] Savulescu and Dickenson (1998) provide a detailed discussion of the ethical issues involved in

that when there is a lessening of responsibility by professionals this still contributes to the client's recovery journey. This trust is based on a certain type of relationship, namely one characterised by mutual respect and regard. If either client or professional lacks integrity and honesty in their dealings with each other, trust will be jeopardised. Clients will cease to see the psychiatric professional as a therapeutic agent and instead view them suspiciously as some kind of social control agent, monitoring their mental state in order to apply the Mental Health Act if necessary. Professionals for their part will view clients suspiciously as people who could complain about their care and, in short, create difficulties for them.   Where trust is low, suspicion tends to be high. Currently, the procedural ethos has generated a high degree of suspicion that is therapeutically unhelpful.

Procedures create a minimal set of expectations around our conduct with others. This is enormously helpful when we are new to something and struggling to make sense of it. The problem is when we see the minimum as not only necessary but also sufficient. In seeing the minimum as sufficient, we lessen the possibility of striving for ideals and for 'pushing the limits'. Clients who are recovering from mental illness need, at some level, to strive for the ideal of health. Part of our ability to strive for ideals is the ability to go beyond minimum standards of conduct. With the reification of procedures in the procedural ethos, 'pushing the limits' becomes unnecessary since the standards of the procedure can be met by minimal endeavour. This is a significant problem for recovery from mental illness. Part Three will discuss how this problem can be addressed.

Another problematical issue is that it has become more difficult to be admitted to psychiatric services. This is partly because of resources but also because psychiatric services are meant to focus upon the severely ill. The threshold for admission into the service (both inpatient and community) has been raised. The result of this tendency is that when people are admitted they are quite unwell (often critically unwell) and need considerable input from psychiatric services. In order to gain admission, clients need to meet quite stringent entry criteria. These criteria are concerned with having a serious mental disorder which can be treated. An initial interview would be used to see if a prospective client met those entry criteria using a set of clear admission criteria with procedures in place for ensuring prompt treatment

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advance directives in the psychiatric context.

for those needing it. This tends to mean that psychiatric professionals assume considerable responsibility for the early phase of a client's recovery. Once having gained admission into the psychiatric services, there are a number of procedures in place for determining the journey towards recovery. It is probably accurate to say that inpatient facilities have more procedures in place than community facilities, but both work with a procedural ethos. The problem here is not with procedures for admission, but with the uncritical acceptance of rigid procedures which prevent treatment for those not currently meeting entry criteria but who will, if untreated, go on to develop a serious mental illness which requires admission. There is evidence[20] that early intervention can prevent illness deterioration and speed up recovery once unwell. Unfortunately, although most psychiatric expertise is tied up within psychiatric services, such expertise cannot (generally) get involved in early intervention since this is seen as a responsibility of primary services. This is not simply a matter of wrong procedures, since every procedure will have criteria and cut off thresholds. The problem is the inability to use any decision-making approach not based on procedures.

While procedures for admission can be problematic, of greater concern is the discharge of clients in a timely and therapeutic manner from the service. There is a tendency for psychiatric services to keep clients for too long. This makes it difficult for clients to assume the necessary levels of responsibility for their own recovery since a certain degree of dependency is created. One of the central features of failing to discharge clients in a timely manner is the creation of dependency in the client. Dependency can be therapeutic at a certain stage of recovery but it can undermine the recovery journey if it is allowed to continue beyond the stage at which it is needed. Sustained dependency in healthcare, as opposed to a temporary dependency, is nearly always untherapeutic[21]. By sustained dependency is meant dependency which continues for a prolonged period of time and in which the client starts to recover abilities and competencies lost while they were more critically unwell but where responsibility for the client's well being still lies with the professional. Temporary dependency is dependency for a short period while the client is more critically or

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[20] There is considerable literature and research to support the need for early intervention, particularly with psychosis. Jackson, Edwards, Hulbert and McGorry (1999) pull together much of this research in a readable and accessible form.

[21] The merits of temporary dependency in healthcare are defended by Campbell (1991), who thinks autonomy has been overemphasised.

acutely unwell. There are a number of reasons for a client remaining longer than they should within services. For example, there might be no one for professionals to refer on to, professionals might like the client, there might be a lack of appropriate accommodation for discharge from inpatient facilities, the professional's desire for control of the client, the client's desire in some cases for someone to take control and responsibility etc. The effect of all these factors is usually dependency. This dependency simply means that the client's current level of recovery is held in place longer than it should be. The abilities and competencies they could acquire if discharged continue to be exercised by psychiatric services. For example, the client may be able to return to full time work but employers are reluctant to employ someone still receiving psychiatric service input. There are many other examples. This inability to discharge clients at the appropriate point in their recovery, whatever the nominal reason (see above), is due to the way in which the procedural ethos operates. The problem is not with the discharge procedures per se, though I think objectively considered there are too many, but with the uncritical reliance upon them for making decisions. Since psychiatric services will often be held responsible if something goes wrong, even for clients discharged from the service, there is a tendency not to discharge. The problem is that, currently, there are few options for discharge that count as appropriate follow up, other than referral to General Practitioners. The result is a bottleneck effect as large numbers of clients ready for discharge 'clog' up the system. Underlying this fear of discharge is, one suspects, the belief that the client will not carry responsibility should something go wrong, but that it will be the psychiatric service which discharged them which is held responsible. Also, there is a misplaced understanding of the justice owed the community. Justice in this sense is for ensuring that someone 'problematically risky' or simply potentially problematic is not discharged unsupervised into the community. This is a misplaced sense of justice, however, since most psychiatric clients pose no increased risk (above the general population level) of harm to the community[22].

A procedural ethos can lead to the 'client's voice' being disregarded and ignored. Although there has been a serious attempt to increase the sense of hearing the 'client's voice' in the past decade or so it is still tokenistic rather than substantive. It

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[22] Ministry of Health (2003) contains interesting information on the connection between homicide and mental illness in New Zealand in the past few decades, showing that the mentally ill are generally no more likely than members of the general public to commit homicides.

has tended to take the form of proceduralising the client's voice, as seen in the last chapter. In this regard, it is doubtful that employing people in roles such as consumer consultants will have much effect on increasing the sense of the 'client's voice' unless they are funded separately and have considerable skills in procedural work. Most of the procedures in psychiatric services have been created by those employed by the service or the funders of the service. The result is that the procedural ethos reflects the values of providers and funders rather than the recipients of care. Other areas of healthcare also share this problem, but, in some cases, have the advantage of a skilled and visible advocacy group that is well funded. Also, a client might experience a procedural ethos as being bureaucratic and rule bound rather than humanistic and responsive if their voice is not heard.

It might be thought that the procedural ethos in the non-governmental organisations and private sector, with their emphasis upon autonomy, would be more client-centred and hence attentive to the client's voice. The reality is, as mentioned earlier, that most procedures are created by those employed by such services. However, (in non-governmental organisations) it could be argued, services have been more successful in promoting the view that client-centred equates with procedures which facilitate and promote self determination based on the autonomy principle. In practice also, there is a tendency to transfer to the public system clients requiring paternalistic interventions or the overriding of personal autonomy, which permits such non-governmental organisations and private services to maintain a focus upon self determination. Self determination and being client-centred are not the same thing: it could be argued that there are occasions when being client-centred means accepting paternalism or the overriding of personal autonomy, when it is justified.

The client can sometimes be caught in the middle of differing forms of the procedural ethos, between the psychiatric and other mental health services. However, as already indicated, when justice and the autonomy principles come into conflict directly there tends to be a reliance on the justice principle. This occurs internally within public psychiatric services when these principles come into conflict and likewise it tends to occur when psychiatric and other mental health services come into conflict. The result for the client can often take the form of any previous work in those other mental health services being ignored or undermined as new procedures (connected to justice) are implemented within the psychiatric services. The absence of a consistent guiding principle behind the procedural ethos can therefore undermine

its practical usefulness. It would be helpful if there were one ethos that connected all the various psychiatric and other mental health services consistently.

Section Two: Effects of the Procedural Ethos on Psychiatric Professionals

The aim of this section is to show the effects of the procedural ethos upon psychiatric professionals. Psychiatric professionals are not, however, an homogenous group: psychiatrists, psychologists, psychiatric nurses, occupational therapists, social workers and psychotherapists have slightly differing needs and responses to the procedural ethos, but there are a number of problematic issues that they share. Later, there will be brief discussion of the particular problematic aspects for psychiatrists and psychiatric nurses, who are the professionals most closely linked to the Mental Health Act.

The common problematic aspects are connected to a lack of reflective practice and the growth of professional expertise. There are difficulties of being able to trust clients in terms of responsibility when a procedural ethos exists and the danger of psychiatric professionals (particularly psychiatrists and nurses) becoming the enforcers of various procedures. Additionally, there are problems with paperwork and form filling within a procedural ethos. Finally, there are the difficulties of interacting with services which have a procedural ethos, dominated by autonomy, from the perspective of the public psychiatric services. I will once again work through these issues one by one.

A procedural ethos tends to reinforce externalised decision-making, as discussed already. A reliance on external means of reaching decisions (such as guidelines, protocols and the like) has implications for how seriously we view internalised models which emphasise reflection. Reflective practice[23] has generated a considerable literature in the last decade that is concerned with the individual critically thinking through issues for themselves, based on their own practice. There are a number of different models of reflective practice but the work of Schon (1983) has been particularly influential. Schon (1983) distinguishes between 'reflection in action' and 'reflection on action'. Reflection in action is the kind of immediate thinking about a situation that arises in the course of practice. It relies on the practitioner identifying patterns from previous encounters and also noticing any small

changes and doing it all quickly and on the spot. Reflection on action is subsequent, retrospective reflection on the action. To do this well in either way requires considerable expertise and experience. This is a continuum well expressed in the nursing literature (though applicable to other disciplines) in the work of Benner (1984). She differentiated between four levels of expertise in clinical practice: novice – someone who is new to a clinical area and who needs rules and regulations to follow in order to understand how things are done in that environment; proficient – someone who has an understanding of the area but still needs to follow rules and regulations quite carefully; competent – someone who has mastered the rules and regulations and can respond to new situations provided they are relatively predictable; and finally the expert – someone who can dispense with some rules and regulations in order to immediately home in on the clinically significant factors. The expert is also able to both recognise previous patterns in terms of the presentation but also respond to novel situations even when the presentations are non-predictable and unusual. To become an expert in this sense involves considerable reflection since following predetermined procedures will not enable a creative response to a new situation. There is, in procedures, a rigidity that can entrap individuals and lessen the possibility of a spontaneous response. In a procedural ethos, where procedures are reified, this effect tends to be emphasised[24].

All services have a range of expertise in the various professional groups. I would contend that the procedural ethos gets in the way of the growth of expertise. It does this by its reliance on external, as opposed to internalised, decision-making[25]. While there is expertise, it occurs in spite of, rather than because of, the procedural ethos. Over time, it is likely the procedural ethos will lead to increased numbers in the earlier stages of professional development (novice, proficient and competent). The implications are less expertise and more clinicians in the earlier stages of professional development that need rules and procedures to understand their environment. The result is yet more procedures and reliance on procedures and hence a reinforcement of

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[23] For example: Kember (2001), Cooney (1999) and Graham (2000) all provide useful information and evidence for the usefulness of reflective practice.

[24] Carson (1997) has described what he calls the 'poverty of proceduralism' by which he means that in healthcare it is the relationships between people, strengthened by reflection which is vital and that this sensitivity cannot be captured by procedures.

[25] There are connections between external and internal decision-making and the psychological notions of internal and external locus of control. Generally, as individuals become more autonomous they tend to desire an increased internal locus of control.

the procedural ethos. Schon (1983) thought that knowledge could be differentiated between high and low or 'high ground' and 'swampy ground'. Some knowledge was not in dispute and more tangible, such as scientific laws, whereas 'professional' knowledge (in health, education or architecture for example) relied on embedded knowledge which had an intuitive quality hard to pin down in definitive statements[26]. That professional knowledge still involves adherence to procedures but that adherence in itself is insufficient and hence there is also reliance upon internalised reflection.

Professionals need to trust that clients will assume responsibilities if they, as professionals, let go of them. Professionals in the earlier stages of development are more likely to follow procedures rather than take 'the risk' of lessening their responsibility. This is because in a risk- averse climate it is the removal of particular responsibilities rather than their continuance that may lead to legal action or disciplinary action. In a service which was dominated by an ethos characterised by a focus upon the recovery of the client, legal action and disciplinary action would be more concerned with the inappropriate continuance of professional responsibility getting in the way of clients' assuming responsibilities necessary for their recovery. The current procedural ethos, for example, militates against appropriate early discharge by psychiatric professionals 'hanging on' to clients just in case they relapse, once again emphasising continued professional responsibility over its removal.

Connected to the concepts of trust and responsibility is the concept of risk. In an increasingly litigious society, there is a tendency for professionals to practice defensively. Risk comes in different forms. Classically, in psychiatric practice, risk to self (which is restricted to include risk of suicide and significant vulnerability) are contrasted with risk to others. These are, however, only some of the risks to clients and others as a possible consequence of mental illness[27]. Risk to self or others is seen as providing a basis for citing the Mental Health Act on the assumption that someone is no longer competent[28]. As already discussed, because of the 'legislative

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[26] Benner and Tanner (1987) have an interesting analysis on the way expert nurses use intuition to improve their practice.

[27] Risk to self and others is a technical understanding of risk based on the Mental Health Act.

[28] Buchanan and Brock (1989) argue that two factors need to be considered when deciding for others: 1) setting and accurately applying standards of competency to choose and decide; and 2) achieving a balance between (i) protecting and promoting the patient's well-being, (ii) protecting and promoting the patient's entitlements to and interest in exercising self determining choices, and (iii) protecting others who could be harmed by patient's exercising of harm-causing choices. This formulation, while commendable, is not without problems. There remains the problem of identifying a harm and who should be allowed to decide these things. Roth et al. (1977) indicates there are five tests of competency:

imperative,' procedures applicable to a small group of clients under the Mental Health Act are transferred to all clients of psychiatric services. So it is with regard to risk which is arguably the basis of the Mental Health Act. All other types of risks are seen as unimportant. Those other risks include: risk to the client of dependency, risk of the lack of recovery through professionals not letting go of responsibilities, risk of side effects of treatments, etc. These risks are more real for most clients most of the time than the iconic notion of risk to self and risk to others.

Psychiatrists and nurses have particular responsibilities for clients under the Mental Health Act. This is because two roles created in the 1992 mental health legislation tend to be occupied by these professional groups. The two roles are: responsible clinician[29] and duly authorised officer. All clients under the Act need to have a responsible clinician. The Act specifies that this must be either a medical practitioner or another suitably qualified and competent professional. In practice, this means psychiatrists and very occasionally nurses or psychologists occupy this role. The role is concerned with co-ordinating and planning care for those under the Act. The role of duly authorised officer is almost always occupied by a senior mental health nurse. This role is meant to interface with the public, in terms of giving advice about the Mental Health Act and also provide an initial reference point for placing people under the Act. Very strict procedures are in place for ensuring procedural justice for clients needing the intervention of staff occupying these two roles. While these roles are meant to assist therapeutically, there is a perception that they are there to interpret and enforce the Mental Health Act. While the Act applies to relatively small numbers of clients at any one time, potentially any client can (if they meet the criteria) be placed under the Act. While it is true that potentially any member of the public can be placed under the Act, it is practically and conceptually easier to do this for someone currently already in the service as a client. The procedural ethos around justice within psychiatric services, because of the role of these two professionals, has been transferred onto all clients within the service. This creates problems for these professionals of being perceived as appendages of the justice system rather than as therapeutic agents. It could be argued that the strictures of the procedural ethos from the criminal justice system have been applied to clients under the Act within

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1) evidencing a choice, 2) reasonable outcome of choice, 3) choice based on rational reasons, 4) ability to understand, and 5) actual understanding.

[29] See Ministry of Health (2002) for more information on this role.

psychiatric services and then to all clients of psychiatric services respectively in a descending manner.

The procedural ethos has tended to create many forms and documents that need to be completed. This has been a particular problem for clinicians who see their primary role as interacting with clients rather than filling out forms. There are different types of form filling and note keeping: i) Forms designed to justify the role of the professional; ii) Forms designed to monitor and assess the mental state of clients; iii) Forms designed to account for how professionals spend their time; and so on. Forms (as in i) that have no intrinsic purpose other than justifying the existence of a professional are hard to defend. An example might be clinical notes, saying the same thing, from different professionals who all attended the same case conference. Note-writing which gives no information about the client but documents what the professional has done in great detail could also be seen in this light. Forms and note-writing which are concerned with the client's mental state are more central to the business of psychiatric services, provided once again these are not duplicated assessments by different professional groups. Forms are vital to the service but generally irrelevant to the individual client. Some balance in how much time professionals spend accounting for their time needs to be struck with the time spent actually seeing clients. Again, the problem is not the existence of paperwork but the inability to use decision-making which is not centred on procedures, in this case procedures around filling out forms.

The procedural ethos underpinned by the justice principle in the public psychiatric services must interact with the procedural ethos underpinned by the autonomy principle in the non-governmental organisations and private services (the 'other mental health services'). The nature of this relationship is hard to fathom. It is the case that the non-governmental organisations and private services frequently use psychiatric services when clients they are seeing become unwell or relapse. This is understandable since psychiatric services are where the most extensive inpatient facilities are and most of the staff who are able to implement and administer the Mental Health Act. Unfortunately, these services (non-governmental and private) view paternalism as being a necessary evil. These views (which are anecdotally quite widespread though not empirically tested) affect psychiatric professionals working in psychiatric services quite deeply. After all, the services they offer are viewed as unethical by some practitioners and clients in those other services. The paradox is

that often no differentiation occurs between the overriding of autonomy through potential risk to others (where justice is the dominant principle) and paternalism through risk to self (where autonomy and beneficence are the dominant principles). There seems to be a greater acceptance of paternalism than of the overriding of autonomy for the sake of justice. There is, then, effectively a degree of competition between the autonomy-based services and the justice-based service. This competition seems to turn on the conflict between the interests of the client (in the sense of self determination) and the wider interests of society. As indicated already, when justice and autonomy are directly in conflict, it tends to be justice which is dominant. This applies between non-governmental and private services and the public psychiatric services. This conflict is nearly always unhelpful. Rather than seeing their services as complementary, there is a tendency for professionals to see them in competition. This tends to prevent the development of any sense of community between these various services.

Section Three: Effects of the Procedural Ethos on Psychiatric Services

While clients and psychiatric professionals may have difficulties with the procedural ethos, psychiatric services themselves also have problems with the adoption of a procedural ethos. I will list these difficulties before discussing them in more detail. These problems are the proceduralisation of recovery that has a tendency to make the service less responsive to the individual client, the downplaying or dismissal of other forms of decision-making and the ever-present procedural creep.

The procedural ethos has led to the ways recovery is fostered being partly proceduralised. The stage approach to recovery mentioned already (see Figure 2.2, p.35) can impact on the way in which we see clients recovering and, in that sense, it can be proceduralised. This is not a critique of the stage approach to recovery, discussed in Chapter 2, which is often a useful guide, provided it can be adjusted for individual clients. The first problem is that this stage approach can be seen as a set of procedures which clients have to pass through in order to recover. The stage approach is not meant to be seen as rigid stages clients have to pass through; it is meant more as a guide. Unfortunately, particularly with professionals early in their career when rules and procedures are needed, these recovery stages can be reified. For people who take this view, anything which deviates from the stages of recovery will be seen as non-conducive to recovery. The implications are numerous: for example, that a particular

client needs to spend a certain amount of time in various recovery stages, that we cannot refer someone on to rehabilitation services because that stage does not apply yet, and so on. Furthermore, there is a lack of consensus around what a 'normal' recovery journey might look like. Given that one of the strengths of the procedural ethos is that it rests upon principles that have arisen out of the liberal consensus, it is easy to see the attractions of consensus. Unfortunately, while there is a developing consensus around what can help someone recover, (for example, diagnosing a particular mental disorder) there is no consensus around what a 'normal' recovery journey[30] should look like. The 'recovery approach' as already discussed (Chapter 1) emerged from the consumer groups who had 'survived' the psychiatric hospitals. As notions of recovery were taken up by psychiatric services in piecemeal fashion over subsequent years, it became increasingly evident that psychiatric services and other mental health services (private and non-governmental) wanted to own this notion of recovery and control it. The proceduralisation of recovery was one way of doing that. However, in stressing a procedural approach to recovery, the lifeblood of what makes recovery as an approach so exciting and potentially fruitful, namely that it is partly about an individual's quest narrative for health, is lost. What becomes important are the procedures: in the sense of who is implementing the procedures and who is responsible for which procedures. This is not to say these procedural aspects are unimportant, only that they should not necessarily be the focus or the final decision-maker. In making procedures the focus of recovery, the system and the services become less responsive to individual clients. This is because procedures lack flexibility and have a certain necessary 'fixed' quality. Individual clients cannot be fitted easily (if at all) into a neat set of stages with accompanying procedures. The result is that clients can experience the service as unresponsive and officious. Clients can often start to lose hope in their recovery when they meet a bureaucratic response to a human request[31]. That lessening of hope can impact on their motivation and their perseverance, all of which can undermine their individual journey of recovery.

Additionally, in making procedures the focus of decision-making, we lessen and downplay the role of other forms of decision-making, of which there are many. Part 3 will focus on these other ways of making decisions, however, while less

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[30] See Lapsley et al. (2002) for evidence as to how individual recovery from mental illness can occur through various stages.

significant than the ways mentioned in Part 3, there are two which are relevant here: professional and evidential decision-making.

Professionals have traditionally stressed professional knowledge, expertise, and training honed by professional virtues. This approach was dominant during the clinical-expert ethos. While clients will always hope that professionals act in their best interests, the corollary of the clinical-expert ethos was that the 'expert always knows best'. This paternalistic notion has progressively become less acceptable and it is a central reason for the gradual waning of the clinical-expert ethos. The problem for many services is that they still have many professionals who subscribe to this perspective and find it difficult to change. In some respects, what services need is the professional decision-making ethos shorn of its overt paternalism. Instead of this 'professional ethos', the procedural ethos has effectively meant that the professional is an interpreter of the procedures.

Evidence-based practice has also become a very important decision-making tool. Buttressed by scientific research and evaluation methodologies, it provides information from which informed decisions can be made. Unfortunately, while evidential decision-making is a useful tool for making decisions, it has become entangled with the procedural ethos. This is the result of many factors but, in particular, the proceduralisation of the research process through ethics committees, grant applications, funding processes and the like. The point is that evidential decision-making is still a hope rather than an actuality. Services do claim to be evidenced–based, but what does this really amount to within the context of a procedural ethos? I would contend that it means that evidence is largely used to support the procedural ethos. This is a large claim but to support it I will mention the following: i) The disproportionate number of audits and evaluations as compared to research studies performed in psychiatric services that tend to support existing procedures or suggest the need for new procedures; ii) The low proportion of site- (or service-) specific research performed and the high proportion of clinical trials on medication that are not site-specific but multi-site. These studies all provide assistance with decision-making at an international level, which then is imposed downwards onto specific services. While such studies may be evidential, how evidential for a specific population group is still debatable; iii) The service-specific research that is

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[31] There is evidence from the literature that hope is a central feature of recovery. See Deegan (1992) for

performed tends to add to service clinical pathways or to practitioner's academic qualifications (arguably helping to create more experts grounded in the procedural ethos).

Finally, psychiatric services provide evidence of 'procedural creep' on a significant scale as part of the procedural ethos. Psychiatric services have traditionally always relied on a powerful informal means of making decisions and organising activities. From the earliest times in the asylum era, there was a whole collection of rules of thumb and custom and practice ways of working which dominated practice. For example, while there was little or no evidence to support the benefits of segregating disorders into different areas of the asylum, it became a part of custom and practice that this occurred[32]. The various roles of doctors and nurses in the later asylum period are full of examples of custom and practice in role demarcation: what doctors do and what nurses usually are not allowed to do. Rules of thumb were evident in the way, for example, that particular treatments were applied. In the absence of good service-specific research, there were rules of thumb for applying particular treatments and in which order. For example, in working in the community it might be theorised about which is the best order for particular client interventions: i.e. medication first, followed by counselling, support, vocational rehabilitation, etc., or some other ordering of interventions. Such theories as there are, are usually based on rules of thumb and nothing more. The research at a specific local level is generally absent[33].

Formal procedures also tend to have a hierarchy within psychiatric services. After rules of thumb and custom and practice approaches there are expert guidelines. These can look very similar to custom and practice approaches, except that they are written down. After expert guidelines there are recommended best practice guidelines, which usually involve some benchmarking of guidelines against agreed standards and research. Then, there are protocols, policies and finally, legislation. Interestingly, the procedural ethos is essentially shaped like a pyramid, with a large number of informal

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an understanding of how important hope can be to clients.

[32] See Williams (1987) for a description of segregation practices in the New Zealand context.

[33] The reverse of this is also true: i.e. where evidence contradicts existing custom and practice it tends to be ignored. The example of providing supportive counselling in the community by community mental health nurses indicates it is no better than standard treatment and yet it continues to be practised.

procedures at the base with progression up the pyramid towards a relatively small number of significant pieces of policy and legislation.

It is the nature of the procedural ethos to be continually creating informal procedures which then move through to formal procedures. This procedural creep is a fundamental aspect of the procedural ethos. It also gives the clue as to why it is so hard to change: change involves changing formal procedures and in the procedural ethos it is the informal procedures which are the foundations and these are not touched by formal change.

Section Four: Effects of the Procedural Ethos in Psychiatric Services on Society

The aim of this section is to show the difficulties for society produced by a procedural ethos in psychiatric services.

There are two problems involved for society in accepting a procedural ethos within psychiatric services. Firstly, is society's attitude towards risk. Risk is often perceived in absolute ways rather than incrementally. Psychiatric services obviously do not exist in isolation. They are part of society and reflect society's needs and concerns. That wider society is generally frightened of people with mental illness. In the clinical-expert ethos, society relied on the expert to do 'the right thing' and ensure such people posed no risk to society by putting them away in asylums. In the procedural ethos, it is the procedures (and the attitude towards them) which determine how people with mental illness will be treated. As already mentioned, society has particular fears about individuals who pose a risk to society due to mental illness. This fear often transfers over to all people with a mental illness, even those who pose no risk to society. The procedural ethos in psychiatric services responds to this need of society by elevating the principle of justice over other principles. Psychiatric services have an obligation to ensure, through procedural justice, that people with mental illness pose no or little risk to society. The problem with this for society is the inability to be sufficiently inclusive towards clients of psychiatric services with this absolute attitude towards risk, which is paradoxical since psychiatric clients *are* part of society.

The second difficulty for society of psychiatric services adopting a procedural ethos concerns responsibility. The wider society seems to have the view that psychiatric services are completely responsible for someone once they are admitted into their service with a mental illness and there should be procedures for

guaranteeing this responsibility. However, if society does not accept that responsibility can not be absolutely placed with psychiatric services, there will be an increased risk to society through clients not feeling included in society and not being permitted to take appropriate responsibility for their own health. Fundamentally, the social contract between psychiatric services and the wider society needs to be rewritten. Instead of a contract which gives the expert the right to do whatever is necessary to protect society and treat the individual, we now have a contract which is based on a rigid understanding of procedures and protocols. Neither of these approaches is helpful for recovery, and instead we need a new contract which acknowledges the responsibilities of psychiatric services, clients of psychiatric services and the wider society.

Responsibility is connected to self determination. As clients start to recover, they do need to assume increasing responsibility for their own health, and society needs to understand the implications of this. It will mean that psychiatric services cannot be held responsible for every single action that a client or former client makes. It will mean that there is a graduated scale of responsibility, a continuum rather than the categorical understanding which currently informs the debate (due to the continued focus on categorical understandings of mental disorder). The responsibility of psychiatric services will focus increasingly not on whether procedures were followed, but on calculated risk decisions to withdraw responsibility for particular activities and transfer them to clients.

Calculated risk (or informed risk-taking) is connected to the idea that in order to recover from mental illness, risks do need to be taken, by the client, the professionals and the service. Society too needs to accept that some degree of risk-taking is necessary rather than the risk averse stance it currently adopts. Calculated risk involves some basic risk/benefit analysis, with higher risks needing to be justified by higher expected benefits.

Unfortunately, the procedural ethos militates against this kind of risk/benefit calculation occurring in psychiatric services because it cannot be easily proceduralised. In its place, as we have seen, is the notion in society that risk and responsibility in connection with mental illness are absolute. As will be shown in Part 3, there are better ways of making decisions than relying upon procedures in an absolute way.

Section Five: Problems with the Overall Pervasiveness of the Procedural Ethos

The problems for clients, professionals and psychiatric services of a procedural ethos are compounded by the acceptance of the procedural ethos in the wider society. Since these problems do not exist in isolation, they all interact and reinforce one another. The result is a procedural ethos which is stronger and more resilient. There are, however, two other problems with the overall pervasiveness of the procedural ethos.

Firstly, because it is so pervasive, over time individuals are promoted who share those fundamental values – that is the procedural ethos based on principles underpinned by the liberal consensus – which yet again serves to reinforce, emphasise and entrench the procedural ethos. Secondly, it tends to mean individuals not so in tune with using procedures as the final decision-maker – both clients and professionals – will not flourish. For clients, this has implications for recovery in that if they are not able to follow a structured proceduralised approach, they may not do well and likewise professionals may find that they also struggle with the rules and regulations even though their interpersonal and technical skills are good.

Summary

This chapter has identified practical problems with the procedural ethos, which have come to characterise psychiatric (and other mental health) services, though differently, in New Zealand as their *de facto* philosophy. Essentially, those problems are based around notions of responsibility. There are problems for the client, professional and service of adopting a procedural ethos. Furthermore, there are problems for the wider society in accepting a procedural ethos in connection with psychiatric services, since it has a tendency to reinforce that ethos.

The problem for clients, as discussed, was the difficulty in their assuming responsibility for their actions in a procedural ethos since there was a tendency to emphasise external decision-making over internal decision-making. This responsibility in turn tends to impact on the trust between professionals and clients and the expectations of their recovery, since procedures tend to emphasise minimal expectations.

Professionals working in a procedural ethos also tend to emphasise external over internal decision-making, which tends to mean reflective practice is not

emphasised. This in turn affects the spread of competencies in professionals in the novice to expert sense since reflection is a vital component of expertise.

Psychiatric services tend to proceduralise recovery and down play other forms of decision-making. There is the ever present problem of procedural creep. Additionally, psychiatric and other mental health services operate with differing principles: within psychiatric services there is an emphasis upon justice, while in the private and non-governmental sector, autonomy is the dominant principle. This has given rise to a certain level of conflict between psychiatric and those other (particularly non-governmental and private) mental health services.

The wider society supports the procedural ethos and particularly the emphasis upon procedural justice; so there needs to be a new social contract between society, psychiatric services and the professionals and clients of those services, in terms of responsibility.

Finally there are some general problems with the procedural ethos in terms of its pervasiveness, with a tendency to promote those who agree with its tenets over time creating problems for those clients and professionals who emphasise other ways of working.   Part 3 will consider how the adoption of a 'recovery ethos' would change psychiatric services in deep and lasting ways.

CHAPTER 6
The Recovery Ethos Part I:
The Virtues

This chapter argues the case for the recovery ethos in psychiatric services using the virtues as a way of making decisions for both psychiatric professionals and clients. It presents only part of the argument for the recovery ethos. Chapters 7, 8 and 9, in which the client-professional relationship, recovery narratives and the psychiatric community are respectively discussed, are also part of the recovery ethos. As has been discussed, the procedural ethos with its reliance on principle-based approaches has become all-pervasive in psychiatric services. However, there are significant problems with this procedural ethos in terms of assisting clients to recover, since it leads to an externalisation of decision-making and difficulties for clients in assuming increasing levels of responsibility, to mention only two problems. The principles of justice and autonomy have become dominant in terms of the underpinning of those procedures, but in different areas: justice in the publicly funded psychiatric services and autonomy in the non-governmental and private mental health services. This has given rise to conflict, or at least misunderstanding, between these various services, which has made it almost impossible for them to have any sense of a common purpose or objective. It has been argued that the procedural ethos and its methods[1] are seriously misguided and that we need a new way of conceptualising the ethos of psychiatric services.

There is an important practical difference between a recovery ethos[2] and a procedural ethos. Much of this difference will be elaborated in subsequent chapters. To briefly recap, the procedural ethos has become the *de facto* philosophy in psychiatric services insofar as decisions are made using procedures of one kind or another and that procedures are reified. The procedures are intimately connected to the principles of justice, beneficence and autonomy. These principle-based procedures have accepted eclecticism for determining ways of promoting recovery. Eclecticism (in the sense of decisions based on the fair treatment of the various health domains) has become a decision-making tool within psychiatric services underpinned by

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[1] Rorty's (1992) paper 'The advantages of moral diversity' develops an interesting argument to the effect that in order for a procedural principle based approach to work, virtues such as respect and tolerance need to be well developed through moral education, thus emphasising the primacy of the virtues.

[2] As already indicated the recovery ethos can apply to all mental illness. This is because the recovery ethos is about how decisions are made about which health domain intervention to use (i.e. biological,

procedures of which the classification system is the most obvious, where the focus is on the treatment of mental disorder.

The recovery ethos does not rest on moral principles. While the recovery ethos may use procedures,[3] these would not be reified as they are under a procedural ethos. The recovery ethos is fundamentally committed to the recovery of the client's mental health through a pluralistic approach to fostering the client's recovery. That pluralistic approach cannot be addressed through procedures as the final decision-maker, since each client and each situation is unique[4]. Rather than resting on moral principles, the recovery ethos relies upon the decision-making capability of clients and professionals using an appeal to the virtues. The other attributes of the recovery ethos will be indicated in subsequent chapters. Rather than focusing exclusively on the notion of mental disorder, which lends itself to consensus decision-making, the recovery ethos can work with both the notions of mental disorder and mental illness. However, for reasons that should be apparent, the notion of mental illness with its underpinnings in a continuum is easier to adapt to a recovery focus than the categorical notion of mental disorder.

The rest of this chapter will see psychiatric professionals and their clients addressed separately. This is because the virtues appropriate to the two groups, while similar, do not coincide.

The case for the virtues in the recovery ethos will be developed in the following sections. Section One will present a general rationale for using the virtues rather than procedural approaches to promoting recovery from mental illness. Section Two will focus on the virtues for psychiatric professionals and will have three subsections: a) will argue the claim that psychiatric professionals need certain virtues, those that allow them to foster recovery in their decision-making (this being the ultimate *telos* of psychiatric services); b) will address some possible objections to

psychological and social) not about the health domain as such. Different mental illnesses will require different combinations of these health domains, including that of self- help.

[3] In the recovery ethos procedures will still be used, as guides, but they would not be the final decision making approach. Decisions would be based on what is for the good of the client rather than following the right procedure. A similar claim can be made for the relationship between the recovery ethos and science. The recovery ethos is compatible with the use of scientific procedures but, since psychiatric services are a human service, scientific procedures are to be used for the ultimate good of the client, not reified.

[4] Which is why the recovery ethos is conceptually based on functionalism and emergence. Pluralism allows for all the various health domains: biological, psychological and social, plus self help but within the unique presentation of the client, all the health domains are seen as important but not equally

the use of the virtues for professional decision-making; and c) will indicate what those professional virtues would be. Section Three will focus on the way psychiatric professionals should aim to foster or encourage the development of virtues in their clients. There will be three subsections: a) will provide a general discussion of the claim that professionals should encourage client virtues as a way of promoting recovery from mental illness; b) will address some possible objections to this claim; and c) will provide a more detailed discussion of what those client virtues should be.

Section One: General Rationale for using The Virtues

The aim of this section is to argue the case for the use of the virtues in psychiatric services. In order to argue for the virtues we will use Aristotelian virtue ethics. There are four main reasons for an appeal to Aristotelian virtue ethics as a way of promoting recovery from mental illness in psychiatric services. Firstly, virtue ethics is primarily concerned with character, that is, with the way character is developed and maintained over time. Secondly, the virtues involve the inner life of the individual, regardless of whether that individual be a professional or a client. Thirdly, virtue ethics is not simply focused on right actions but also on the goods that people should pursue. Finally, the virtues have a common appeal that can cross cultural and religious barriers. Implicit in my argument is the assumption that those characteristics are just the ones needed to promote recovery. These points will be discussed one by one.

Before discussing these four points, however, it will be helpful to briefly discuss Aristotle's understanding of virtue[5]. Aristotle thought that a fulfilled or happy life is one lived in accordance with virtue. Virtue, according to Aristotle "is a purposive disposition, lying in a mean that is relative to us and determined by a rational principle, and by that which a prudent man would use to determine it" (NE BK II 1106b9-1107a1). This definition indicates how important the notion of disposition was to Aristotle's understanding of virtue. Disposition, according to Aristotle, is part of our nature as individuals but is not fixed at birth. In other words, disposition, and hence virtue, is something which can be trained. In order to train our

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so at that moment. In other words we can not collapse any domain into another. An emergent understanding of the 'mental' based on functionalism provides the best basis for this.

[5] Aristotle (1981) *The Nicomachean Ethics (NE)* is the primary source for this chapter. However Hutchinson (1986), Urmson (1988) and Hughes (2001) have assisted with the interpretation of that primary, difficult text.

dispositions to become good dispositions, we need to make good choices. What enables us to make good or bad choices is something which Aristotle called practical wisdom. As we will see later, for recovery to take place it is crucial that both client and professional possess the virtue of practical wisdom. For Aristotle, pursuing virtue is, therefore, a rational activity in which we can train our dispositions towards moderation.

The first reason for appealing to the virtues is that developing a certain sort of character is necessary (though not sufficient) for both recovering from mental illness and promoting such recovery. This can be seen to relate to clients and professionals respectively. Aristotle's understanding of character can help in this matter. Aristotle discusses the excellence of character in relation to the doctrine of the mean. Hence, the virtue of courage, which is necessary for recovery from mental illness, can be seen as a mean between rashness and cowardice.

Aristotle distinguishes between four states of character. These are, in decreasing merit: the totally virtuous person, the character relying upon the strength of the will, the character who displays weakness of the will, and the person who does not possess the relevant virtue. The totally virtuous person is the man who wants to act appropriately and does so without internal friction. Secondly, there is the character relying upon the strength of the will. This is the state of the man who wants to act improperly but makes himself act properly. Thirdly, there is the character who displays weakness of the will. This is the state of the man who wants to act improperly, tries to make himself act properly, and fails. Fourthly, there is the person who does not possess the relevant virtue. This is the state of the man who wants to act improperly, who thinks it is an excellent idea to do so, and does so without internal friction. Aristotle sees the will as fundamental to the development of a particular sort of character. He explains the phenomenon of weakness of the will (or incontinence) as a conflict between the desire or appetite for immediate pleasure and rationality (i.e. doing what one knows is the right thing). So, unlike the intemperate man, (the one who lacks virtue, hence does not know what is good for him) the weak-willed person knows what to do but has a stronger desire for immediate pleasure. The notion of the strength and weakness of the will is important for understanding the discussion of which virtues are needed by clients and professionals in order to promote client recovery. A client or professional may be disposed towards a particular virtue, such as

honesty, but unless there is a strength of will to overcome competing appetites the virtue will not be developed.

The second reason for emphasising the virtues is that they are concerned with the inner life of the individual. By inner life is meant the thoughts, intentions, feelings, motives, choices and beliefs of clients and professionals. Virtue ethicists argue that in order to live well, we need to develop certain virtues or character traits rather than simply follow set rules or procedures. In the context of recovery from mental illness, it is the inner person which is primarily the focus since it is the inner person who needs healing or who needs to heal.

The third reason for using a virtue ethics approach is that it is not focused upon right actions but upon the good that we are trying to achieve. In the case of psychiatric services, that good is client recovery from mental illness. During the clinical-expert ethos, finding the right action was seen as the central purpose of psychiatric services; the right action being the one that the expert thought would cure the disorder. During the procedural ethos, the right action was seen as following the right procedure derived from a principle. Under a recovery ethos, the focus shifts to the agent rather than the action. In that sense, Aristotle's approach[6] can be described as agent-centred rather than action-focused.

When Aristotle discusses the development of character or the inner life, he is doing so in relation to his notion of the Good. The Good is the ultimate goal that we are aiming at in life (Aristotle refers to this as the *telos*). The life that is happy and fulfilled and lived in conformity with the Good is referred to as *eudaimonia*. *Eudaimonia* is about the ends of human striving; it is also about the good life and the good towards which we should be aiming. Recovery can be seen as the common goal for psychiatric services. The character traits that are considered to be virtues depend upon this goal, and narratives (see Chapter 8) are a means of promoting these virtues (through moral education).

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[6] There is a considerable and growing literature on the virtues and their application to healthcare. This literature has taken central ideas from Aristotle and developed them into contemporary 'virtue ethics'. This endeavour has many positive attributes but is has one very serious negative attribute; namely a tendency to place virtue ethics alongside utilitarianism and Kantianism as being another substantive ethical theory. Excellent examples of this tendency are: Crisp and Slote (1997) and Hursthouse (1999). In a diverse modern society, agreement on any substantive ethical theory is unlikely. Aristotle in the *Nichomachean Ethics* was more interested in working upwards from the common experiences of ordinary people towards ethical problems than with developing a top down ethical theory. Whether Aristotle would be considered a virtue ethicist today is at least debatable.

The fourth reason for focusing upon the virtues is that they can potentially cross religious and ethnic divides. If the virtues are unhooked from particular religious beliefs, there is the possibility of achieving considerable agreement around the virtues needed by both clients and professionals in order to facilitate recovery from mental illness. There is a near universal agreement across cultures that some character traits are virtues; for example, honesty. Aristotle's emphasis on social relationships, and friendship (NE Bks VII and X) in particular, also provides an illustration of this attribute. Aristotle thought friendship was necessary for human flourishing. He saw the main elements of friendship in terms of sharing, disinterested concern, liking and mutual respect. These elements are, for Aristotle, as true for the relationship one has with oneself as for one's relationship to others. Therefore, if the main features of friendship are connected to love for the friend, we need to say that the virtuous person loves himself in the sense of having self-respect. Aristotle's point can be understood in relation to clients who have a serious mental illness, in that clients often do not like themselves because of self stigmatisation (i.e. the internalisation of the societal stigmatisation of mental illness). Part of the recovery process is learning to like oneself again and, in line with Aristotle's argument, that is connected to learning to love the virtues in oneself as they are manifested. Virtues such as friendship and self love can be seen to have a universal rather than a culturally relative appeal when applied to recovery from mental illness.

Section Two: Virtues for Psychiatric Professionals

The aim of this section is to show the way psychiatric professionals need to adopt a virtue-based approach to promote recovery from mental illness in their clients.

a) In addition to the four general reasons already given, there are specific reasons why psychiatric professionals need to take a virtue-based approach in their decision-making. Firstly, a virtue-based approach allows flexibility in dealing with specific circumstances not found in procedural approaches. Secondly, a virtue-based approach can assist professionals to develop a therapeutic character.

The procedural ethos tends to encourage decision-making based on rules, procedures and guidelines. As we have already seen, the recovery criteria are based on symptoms and functioning from both a client and professional perspective. The problem is that, in the procedural ethos, recovery is promoted using eclectic

procedures that are applied in an inflexible manner irrespective of the circumstances. The pluralistic approach to promoting recovery, where decision-making is not based on rules or procedures, but upon psychiatric professionals and clients using a virtue-based approach, can respond better to the particular circumstances. The development of professional virtues is a critical part of enabling professionals to make decisions without recourse to rules and procedures as the final decision-maker. The virtues (and the other components of the recovery ethos to be discussed in Chapters 7, 8 and 9) achieve this by permitting the professional to make decisions that fit with the particular circumstances before them. In this sense, a virtue-based approach allows greater flexibility and adaptability, which is a vital part of being able to promote recovery pluralistically.

Secondly, the development of professional virtues enables the realisation of a therapeutic character for professionals in a more conscious and intentional way than can occur with a procedural ethos. While the development of character was something mentioned in the earlier generic reasons for an appeal to the virtues, for the professional such a focus brings with it the possibility of developing a therapeutic character. When a psychiatric professional develops a therapeutic character, there is a particular combination of virtues (what these are will be discussed later) that works for the ultimate *telos* of psychiatric services, namely the recovery of clients from mental illness.

b) There are two main reasons why this appeal to the virtues, in the Aristotelian sense, may not seem convincing for promoting recovery from mental illness from a professional perspective. This sub-section will briefly raise these two objections, offer an initial response to them and, in subsequent sections, show in more detail the way the virtues can respond to these concerns.

Firstly, the virtues are thought to be too vague and indeterminate to provide a basis for promoting recovery. The view here is that the virtues lack exactitude, that it is hard to know which virtue should be exercised, and whether people have the same working definition of particular virtues. Mental illness and psychiatric practice generally are already seen to be a vague and inexact area of healthcare. In order to promote recovery from mental illness we need to be increasing scientific rigour, not creating more uncertainty. In other words, the thought is that the virtues are inherently vague and indeterminate.

There is some merit in this view. Virtues are quite vague. People's characters are dynamic and change over the course of a person's life. They are not exact. However, if we are expecting virtues to be exact and precise we are probably having unrealistic expectations of them. Aristotle himself commented on how practical wisdom enabled us to have an appropriate expectation of the level of rigour and exactitude we should expect from our enquiries. Aristotle was of the view that morality, for example, would never be capable of the kind of exactitude we would expect from mathematical thinking. The main defence of the virtues in terms of their being vague and indeterminate is that this characteristic is shared with other approaches, such as principles. The difference is that principle-based approaches have not been successful in delivering the intended exactitude in terms of helping clients with recovery-based decisions, whereas virtue ethics makes no such claim to exactitude. Instead, virtue-based approaches have stressed the way in which virtues can help to guide our actions. Subsequent sections will indicate the way virtues can, to a sufficient degree, meet the requirement for clarity and precision.

Secondly, it could be said that the virtues are insufficiently practical in terms of helping us to make choices between particular recovery-focused actions[7]. This objection is particularly centred on how choosing a particular virtue actually helps with practical decision-making. As Crisp and Slote (1997) indicate, having a particular virtue does not show you when to apply it. In other words, virtue ethics fails to show how having a virtue explicitly connects with decision-making.

While this objection has some merit, as Hursthouse (1999) shows, the virtues do offer a very practical way of understanding, justifying and accounting for actions. The following offers one way of understanding how this could work in the context of recovery. Having gone through a process of deliberation about a particular decision, the professional or the client will make a choice (for which they will take some amount of responsibility) and this will result in an action. Such an approach will not always generate the same action, since the action is determined by the internal deliberation of the professional or client drawing on both moral and intellectual virtues. The amount of responsibility the professional or client should take for the

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[7] There is a considerable body of literature on virtue ethics. Crisp and Slote (1997) indicate some of the practical difficulties of using virtue ethics. Hursthouse (1999) provides a defence of the merits of virtue ethics.

action will depend on the level of collaboration between the professional and the client. Chapter 7 will consider these issues in more detail.

It is important to realise that the virtues are not incompatible with the use of principles. Aristotle was certainly sympathetic to the need for principles to assist with making decisions. The important distinction, however, concerns the origin of principles and the attitude of professionals and clients towards them. In other words, with regards the origin of principles, we need to know whether they are externally or internally generated. Internally generated principles – dependent upon a particular personal and professional stage of development – are entirely compatible with a virtue-based approach and address some of the possible criticisms of the virtues as being impractical. Finally, as seen in the previous chapters, principle-based procedures within a procedural ethos are seen as the final decision-maker, and the attitude towards them is uncritical. In a virtue-based approach, principle-based procedures are never the final decision-maker.

The following discussion will show the way in which the virtues can practically help clients and professionals make practical decisions, in terms of promoting client recovery.

c) Psychiatric professionals can assist with the recovery of clients from mental illness. This sub-section will explore the virtues that those professionals need in order to assist with that recovery. While the role of psychiatric professionals can be overstated, it is probably reasonable to say that they can have a decisive role in helping (or hindering) the recovery of clients. Indeed, while we may assert the centrality of recovery as the goal for clients, it is arguably the case that healing (which is the ability to bring about recovery) is the central goal for the health professional.

Healing has been seen as a central role for medicine at least since Hippocrates. Psychiatrists, as trained doctors, would accept this role. Other psychiatric professionals – psychologists, nurses, social workers, occupational therapists, and psychotherapists – have also, partly through the influence of medicine, defined their roles in terms of healing. Healing as both an art and a science is concerned with the active role of the health professional in restoring the well being of the client. In other words, healing is primarily about the good of the client. This focus on healing and the good of the client is also the fundamental attribute of the health professional.

The psychiatric professional can include all of the above professional disciplines and arguably also the emergent group of mental health support workers. A professional, in this sense, is committed within their sphere of competence to the healing of the client as their primary imperative. 'Professional virtues' can therefore be shared between psychiatric professionals and they are not the preserve of any one group.

Do professional virtues as such actually exist? Or are they simply relevant virtues when exhibited by people in professional roles? In this connection Pellegrino and Thomasma (1988) have provided the best available response in the Aristotelian tradition. They do this by drawing on the notion of virtue and its relationship to the ends and purpose of human life. They note that "to be a virtuous physician, one must also be the kind of person we can confidently expect will be disposed to the right and good intrinsic to the practice professed" (p.116). The focus for Pellegrino and Thomasma is medicine, and hence the use of the word 'physician', but in psychiatric services there is an increasing recognition that all the psychiatric professionals have distinctive skills and knowledge sets that are important for assisting the recovery of the client.

While all the psychiatric professionals can have something to contribute towards the recovery of the client, they all have differing areas of expertise and competency, which is why a pluralistic approach to promoting recovery has been emphasised. There is, therefore, an assumption in discussing the following virtues that all these psychiatric professionals have the virtue of technical competency in their area of expertise and that they are aware of the limitations of their competency. This is important in whatever field of endeavour we are concerned with, but particularly important in psychiatric services where there are so many professionals involved. Historically, it could be argued that psychiatric services have tried to be all things to all people and in the process have over-reached themselves, that is, they have become involved in areas where they have little competency or expertise; for example, by advising on housing or employment or on how to be mentally healthy, given that psychiatric services are actually focused on mental disorder rather than health. This technical competency in working with mental disorder, while necessary, will never, in itself, be sufficient to constitute the virtues needed to assist with client recovery. This is because technical mastery essentially relates to the professional's knowledge and skills in working with mental disorder, rather than the way in which that knowledge

and skill is used. It is in this area of how we do things that the moral virtues can have a crucial role to play. Chapter 2 specified two criteria for recovery, namely symptom reduction and functioning. Technical virtues are essential in knowing what needs to be done to help someone in terms of their symptoms and functioning, whereas moral virtues become more important in understanding the way in which those technical virtues should be implemented. The following virtues show the virtues professionals need in order to have a therapeutic character. These virtues are recommended with some tentativeness in that they should be seen as issuing guidelines rather than prescriptive procedures that need to be strictly adhered to.

Responsibility

The virtues connected to responsibility are crucial in terms of recovery. How clients need to embrace the virtue of responsibility in order to recover from mental illness will be discussed later. This section will provide a parallel account in terms of psychiatric professionals accepting appropriate responsibility for their actions.

Responsibility is the virtue of accepting moral accountability for an action, however, this is rarely a clear-cut matter in psychiatric services. Psychiatric professionals need to accept that they have significant responsibility for the well being of clients in the early period of their admission, particularly if they are admitted in a crisis state. This responsibility can often take the form of the professional exercising justified paternalism when the client is admitted under a section of the Mental Health Act, for example. Under these circumstances, the virtue of accepting their legitimate responsibility is an important virtue for professionals that will contribute significantly to the client's eventual recovery. If a professional was to reject the virtue of responsibility, the client would be left with accepting too much responsibility.

While the virtue of accepting their legitimate responsibility is important, it is also important that the professional is actively seeking opportunities to safely pass some responsibility to the client. In other words, the virtue of responsibility is also connected to the professional understanding of when moral responsibility should pass to the client. This may involve small incremental transfers rather than wholesale transfers of responsibility. For example, when admitted in a crisis state, many clients give little thought to food and water. Under those circumstances professionals would initially make most of the decisions connected with meals. Rather than seeing food and water as one area of responsibility, however, we can break it down in to a number

of discrete activities: when someone eats, how much they eat, what they eat, who they eat with, and so on. Responsibility can be passed from the professional back to the client as soon as this appears to be warranted in each discrete area, that is, when the client is able to assume that responsibility safely and competently and when it is unlikely to interfere with their wider recovery. This can be a difficult process for both client and professional and one that cannot be effectively proceduralised, but requires exercising the virtue by judging intuitively how much responsibility is appropriate for a particular moment. The professional can feel comfortable in a relationship characterised by a power imbalance, where as professionals they have the power and where it can be difficult to let go of that power in a therapeutic way. Responsibility for activities or functions cannot simply be handed over from the professional to the client. The professional virtue is to withdraw responsibility for performing a particular activity, to the extent and in ways that are appropriate, communicating with the client their need to assume that responsibility. The client then needs to assume responsibility for the activity. This notion of a transfer of responsibility is in contrast with the idea of the professional giving the client responsibility for an action. The professional can never give responsibility for an activity to the client, only create the conditions under which the client can assume that responsibility.

Recovery is not a linear process and hence sometimes clients can take more responsibility than they are capable of assuming which can contribute to a small relapse in their mental illness. In these circumstances, exercising the virtue of responsibility means that psychiatric professionals may need to assume responsibility for that activity again on a short-term basis.

Loyalty

Loyalty is the virtue of staying in a relationship with people or organisations, even when there are disagreements and difficulties, and not choosing an exit strategy. Loyalty is important for psychiatric professionals in order to provide a safe space in which clients can try out new responsibilities. There are two forms of loyalty for psychiatric professionals that, while related, are often compartmentalised differently: loyalty to individual clients, and loyalty to the service. Loyalty to clients involves the psychiatric professional staying with their allocated or referred caseload, unless there are therapeutic reasons for discharging from it. Some of those reasons might be based on gender, age, rapport between professional and client or significant

tension. Within psychiatric services there is a relatively high turnover of staff, particularly in some professional groups such as nursing. The implications of this high turnover are that clients can often see many different professionals in the course of their admission, often repeating the same information, replicating assessments and care plans. Such a turnover will impact on how collaborative the client is able or prepared to be with psychiatric professionals. Professionals need to be loyal to their client group, not discharging clients simply because they are difficult or take up too much time.

The second way in which professionals can exhibit loyalty is through loyalty to the service. This is often not seen as a clinical matter but as an issue for recruitment and retention. Given the importance for a client's recovery that they have familiar professionals who stick by them through the course of their illness, it is significant that psychiatric services lose relatively high numbers of staff from all disciplines. However, this matter (rather like the long-term side effects of psychiatric medication) is not openly discussed. If psychiatric professionals are committed to client recovery, it follows that they need to be more loyal to their services.

Loyalty, as Fletcher (1993) indicates, can be seen as a continuum with minimal loyalty based on the maxim 'Thou shalt not betray me' and maximum loyalty on the maxim 'Thou shalt be one with me'. Loyalty – even within the current procedural ethos – is viewed as important, but tends to be of a minimal variety. For the client, this minimal variety of loyalty takes the form of expectations around the privacy and confidentiality of information that they share with the professional: whereas, for the professional, it often takes the form of expectations around the client not officially complaining about treatment or conduct. This is a very minimalist understanding of loyalty.

The kind of loyalty that will be most productive in terms of recovery is a loyalty based on mutual commitment to the relationship between professional and client where both share their expertise[8]. This kind of loyalty falls far short of the maximal variety mentioned above, but still offers a significant improvement on the minimal variety.

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[8] Client expertise refers to increased understanding and awareness of the experience of mental illness.

Sympathy and Compassion

Sympathy refers to the primitive response towards another person's suffering. This apparently common sense notion of sympathy is one defended by, for example Taylor (2002), who argues that sympathy is primitive in that it just happens to us and cannot be broken down or reduced into more basic concepts.

A more famous account than Taylor's is that offered by Hume (1978). Hume's account provides an explanation – almost psychological in nature - of how the suffering of another person is communicated to someone else and how that other person comes to experience the pain they are suffering. In other words, Hume's account of sympathy is essentially about the way suffering is communicated to an onlooker. Such an account tells us little about the nature of that suffering but only about the sympathetic response engendered in ourselves. In a psychiatric context, such an account is not helpful. When confronted by psychic distress, we need to understand what that suffering means for the person suffering, not what it means for us. As will be indicated later, sympathy by itself is insufficient and needs the virtue of compassion, in order to understand what the suffering means.

Without the virtue of sympathy in the sense indicated for someone's psychic distress, the psychiatric professional would be unable to acknowledge and thereby respond to another person's distress and suffering. Too little or too much sympathy could be equally unhelpful. Too little sympathy will mean that there is this inability to respond to the suffering in others. For the psychiatric professional too much sympathy can mean an important attribute of professionalism will have been lost, namely the ability to have a certain objectivity in assessing and responding to problems.

Sympathy is a virtue, which though learnable, is probably established early in life. Hence, while it is true that psychiatric professionals need the virtue of sympathy to acknowledge and respond to someone else's suffering and hence assist them with their recovery, if someone lacks this sympathy it will not be easy to acquire. This probably means that it should be seen as a prerequisite for working as a psychiatric professional that prospective employees in this field possess basic sympathy.

Sympathy goes to the heart of the motivation for working with people who are psychologically distressed. What motivates people who are confronted by human suffering? Is there a deep concern to relieve that distress, or are there other

motivations? Human beings are complicated and there are often many motivations involved in any activity. However, while there may be other motivations present (the need to earn a living, status, prestige, etc.) the motive of relieving the distress of others would need to be present and arguably a dominant presence in any mix of motives. Given that sympathy is a primitive response of humans (and probably other species) to the presence of suffering in others, it might be claimed that it is constitutive of what it means to be human. Such a view, unfortunately, would seem too optimistic, given the intentional suffering that humans have caused to other humans. While it may be considered a primitive response, sympathy is far from having a dominant presence in human enterprises such as psychiatric services.

Sympathy is a necessary virtue in order to have the virtue of compassion. Compassion is the virtue of understanding another's suffering. Psychiatric professionals need to do more than simply acknowledge and respond to the suffering of others, they also need to understand it[9].

Integrity

While psychiatric professionals need to have sympathy and compassion for those they are attempting to help, an ability to show a certain loyalty to those whose mental illness lasts for a period of time, and the capability of facilitating clients to assume increasing levels of appropriate responsibility for their own well being, they also need to behave with integrity. Integrity is the virtue of behaving with respect, sincerity and genuineness in our dealings with others.

Integrity is the main virtue that prevents exploitation or abuse of clients. This is particularly important when dealing with people who may be vulnerable due to their mental state. Without the integrity of professionals, clients can find themselves prescribed treatments they do not need or placed on sections of the Mental Health Act that are unnecessary. It is also a precondition for the possibility of a mutual collaborative partnership between professional and client.

Patience

Psychiatric professionals need the virtue of patience when working with people who are recovering from mental illness. Patience is the virtue of being able to

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[9] Van Zyl (2000) offers a helpful discussion on the nature of compassion and its connection to sympathy.

wait for an outcome. Its significance for recovery from mental illness is that recovery can be a slow and drawn out process where the professional needs to be able to wait for a discernible outcome. It is particularly important for the professional to learn that they need to go at a pace of recovery collaboratively agreed with the client. Historically, this pace has been determined almost completely by the professional.

Aristotle's (NE Bk IV 1125b14-34) conception of patience is perhaps helpful. He saw patience as being connected to anger in the sense of its being an intermediate state. He saw the patient man as one who "gets angry at the right things and with the right people, and also in the right way and at the right time and for the right length of time." In a sense it is necessary to have a certain anger towards overcoming mental illness and sometimes also towards helping clients who need to overcome an illness. While – and I think this is what Aristotle is getting at here - a certain level of anger is important for professionals when working with clients who show no inclination to help themselves and take the next step, it is important that this does not become an excess or deficiency of anger. An excess of anger towards clients who are not making the necessary effort to overcome the illness will tend to mean a lack of patience in the professional. Professionals who lack patience in allowing the client to go at their own pace will be unsupportive and unhelpful towards clients. The opposite deficiency, as Aristotle termed having little anger towards something, is also unhelpful, since being too patient can itself be a problem. A professional who is too patient will be too accepting of clients' not trying or attempting to move on with their recovery. As with all these virtues, there is a need for the professional to find some middle course, that involves being neither too impatient nor too patient.

Patience as a virtue is important for professionals in order to support client recovery. The patient professional is able to go at the client's pace but also able to show some necessary anger towards backsliding and laziness.

Tolerance

For the psychiatric professional who is loyal, sympathetic, compassionate, patient and able to facilitate clients in assuming increasing levels of responsibility it is of paramount importance that they are also tolerant. Tolerance is the virtue of accepting difference whether that is due to people's behaviour or mental state. Psychiatric professionals need this virtue in order to be able to work with clients from

different cultural groups and with clients with different belief systems as well as with clients who simply have a different lifestyle to that of the psychiatric professional.

Psychiatric professionals who are intolerant towards these factors in these ways will tend to be judgmental and hold preconceptions about the capability of particular types of clients to recover. These views will inevitably impact upon the actual performance of clients. Such professionals will, therefore, be less therapeutic than their more tolerant colleagues. An example of intolerance is a professional who has particular views on how clean someone's home should be, expecting everyone else to live by their own standards and being intolerant of anything less than that standard.

While psychiatric professionals always need to be tolerant of the people they are trying to help – since their societal role is a therapeutic one (unlike professionals employed in the justice system for example) - that does not mean being tolerant of all behaviours. Some behaviour does undermine any hope of recovery from mental illness and a therapeutic professional needs to differentiate between tolerance of the person and tolerance towards particular behaviours. In the example above, there clearly are levels of uncleanness that cannot be tolerated for health reasons. Or again, in the case of illicit drug use it is generally unhelpful and undermining of recovery and so it is important for the professional – while accepting the client has a right of choice – to indicate their intolerance for that type of behaviour because it is not in the real interests of the client.

Collaboration

Psychiatric professionals need the virtue of being able to work with clients. There will be further discussion about collaboration in Chapter 7 when we discuss a particular model for client and professional interactions. This section will highlight the three conceptual phases of collaboration and how they impact on the recovery journey.

First, however, it is necessary to distinguish between collaborative behaviours and a collaborative personality. A collaborative personality is an essential part of being a psychiatric professional and it is the basis of the virtue of collaboration. A collaborative personality is based on internal thoughts, motives and feelings that are collaborative in nature. In contrast, collaborative behaviours are

outward displays of collaboration that may or may not be based on collaborative virtues.

Initially, when a client is admitted into a psychiatric service they will look to professionals to assist them and take the lead either because they are in crisis or simply unfamiliar with the service. This period can be termed a professional-led collaboration, that is, the onus for initiating activities and processes falls on the psychiatric professional. However, the professional should still be committed to establishing and facilitating as much collaboration as possible with clients. In some cases, for example when the client is psychotic, this collaboration will be quite minimal. The professional – acting in the best interests of the client – will make most of the decisions and in some cases – having attempted and failed to gain the active involvement of the client – the professional will make decisions without the involvement of the client. This professional-led collaboration should always be seen as graduated in that over time, progressively, the client will assume increasing levels of responsibility. For some clients, however, there will always be some element of professional-led collaboration about their care, because the client is either unable or unwilling to accept responsibility for their own care.

Professional-led collaboration should be seen as a precursor to true collaboration or partnership. In this phase of collaboration there is a mutual respect for the expertise that both professional and client can bring to the encounter, the professional possessing their knowledge of mental disorder and the client possessing expertise in their own personal experience of mental illness. This partnership is characterised by negotiated decision-making. While the professional-led collaboration may have employed consultation in the earlier phase, real negotiation is necessary during the partnership phase since sometimes the determining factor is expertise in mental disorder and its treatment and sometimes the determining factor is a personal experience of recovering from mental illness. In this partnership phase of collaboration, it becomes important for both professional and client to respect each other's perspective with regards to improvements in symptoms and functioning. For example in rehabilitation, clients will still often be on medications of various types; these medications will have a variety of side effects that impact on the clients' abilities to work or sustain relationships. In negotiation, the client's experiences of being on the medication can be brought more centrally in to the decisions around dose and type of medication, thus ensuring a more individualised approach is obtained.

The third stage of the collaborative approach is client-led collaboration, which is for those clients who are advanced in their recovery from mental illness and are able to assume the main responsibility for their own well being, but who still require some expertise from psychiatric professionals. The client will decide how they will use this expertise. The psychiatric professional who is secure in their role and the therapeutic use of their role will have assisted this increasing acquisition of responsibility by the client. Through their loyalty, patience and sympathy for the client's well being, they will be able to make the necessary transition to being the junior partner in the collaborative relationship.

The important point about collaboration is that it should always be individualised. Each client's recovery journey will be different. There can be no one size fits all approach to recovery and collaboration. One client may need to spend two weeks in phase one of collaboration, while another may need to spend a year. The deliberation by both client and professional in terms of recognising the signs that indicate it is time to move to the next stage is a matter of practical wisdom.

There will be further discussion about the way collaboration changes over time in the discussion of developing a recovery narrative in Chapter 8.

Practical Wisdom

Psychiatric professionals need practical wisdom in order to know where the boundaries are between patience and impatience, tolerance and intolerance, when and how to move from one collaborative stage to another and thereby increase the responsibility of the client. Practical wisdom is fundamentally about being good at thinking about what one needs to do in order to achieve one's goal. For psychiatric professionals that means being good at thinking about what will help a client recover from mental illness.

Deliberation is fundamental to practical wisdom, as an intellectual activity. There are four aspects to consider in understanding practical wisdom, all of which need some form of deliberation. Firstly, the professional needs to be able to deliberate about what stage of the collaborative relationship has been reached (i.e. professional-led, partnership or client-led). This is because in the professional-led collaboration it is the professional's prime responsibility to initiate activities, ensure client safety and to facilitate the client's assumption of greater responsibility, provided it is safe. For example, the professional needs to know that they will exercise a prime decision-

making role during a crisis or while the client is acutely unwell; this will extend to decisions on the requisite medication, the client's daily activities, and needs for sleep and food. During the partnership phase of collaboration, the professional increasingly accepts the expertise of the client in knowing and understanding their own recovery journey. For example, the client may decide that they would like to rejoin the workforce. The professional knows that their current medication regime is causing the client to feel very sedated and tired, to such an extent that work would be difficult to sustain. The negotiation might well centre on how to safely reduce the medication dose so that the client can rejoin the workforce while ensuring the dose is sufficient to prevent a relapse of the mental illness. The final collaborative phase, the client-led collaboration involves psychiatric professionals deliberating on how to support the client as they pursue their goals and objectives. Deliberation in this context is sometimes frustrated by situations in which a client relapses and hence where the professional once again is required to exercise increased responsibility, if only for a short period of time.

The second aspect of practical wisdom, and largely a consequence of the first, is recognition of the respective levels of responsibility that the client and professional need to exercise. This is a pivotal component of practical wisdom since it involves deliberating about historical antecedents, the current situation and the future implications. In terms of historical antecedents, the professional needs to assess how the client has coped (if at all) with assuming responsibility for certain activities in the past. Is there a pattern that can be discerned in terms of how the client deals with this particular responsibility? The current situation involves assessing the client's mental state and their current level of functioning and trying to determine their current competency. These past and current assessments are then fed into a set of prognostic projections as to how the client is likely to deal with the particular responsibility in question.

The third consideration for practical wisdom, determined by the second, is that having made some determination on the level of responsibility a client can assume, this then translates into actions in terms of whether it is the client or professional who should accept responsibility for becoming, for example, intolerant towards particular actions or impatient with the pace of recovery.

Fourthly, all these aspects of practical wisdom are fundamentally about prioritising. The professional is bombarded with information. However, it is not all

equally important at this particular moment and the deliberations of the professional are centred on what is important at the moment for recovery to occur for this particular client.

Professionals sometimes get it wrong, even if they employ practical wisdom. Practical wisdom as an intellectual virtue cannot be separated from the moral virtues of loyalty, sympathy, patience, tolerance, collaboration and responsibility. This unity of the virtues is fundamental to understanding how they can assist with client recovery.

Section Three: Development of Virtues in Clients

The aim of this section is to show how psychiatric professionals should aim to foster or encourage the development of particular virtues in their clients.

a) In conjunction with the four general reasons already given, there is a specific reason why psychiatric professionals should aim to foster and encourage the development of particular virtues in their clients,[10] namely, in order to recover clients need to lessen their symptoms of mental illness and increase their functioning ability. Acquiring particular intellectual and moral virtues will greatly assist them to reduce their symptoms and to increase their general functioning. The exact virtues will be discussed later.

b) There are two possible objections to the use of virtues in promoting client recovery. Firstly, an objection is to say that virtues (unlike skills[11]) are not teachable.[12] Virtues and vices are established so early in life that no amount of teaching or education can help us to unlearn bad practices. There is some truth in this argument and it is one with which Aristotle would probably agree. Virtues and vices are largely established in early childhood. However, virtues are habituated ways of behaving and so, like skills, they can be learnt to some extent even in adulthood. The virtues needed for recovery from mental illness can be acquired over the long term and since many mental illnesses have a chronic duration, this becomes more possible.

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[10] I am not suggesting that client virtues, with regards recovery from mental illness, only come from psychiatric professionals, only that it is a key part of the role of psychiatric professionals to teach and foster such virtues in their clients.

[11] The difference between skills and virtues is not straightforward. A virtue, in a professional sense, would simply provide a broader and deeper understanding than a narrowly focused skill. For example, professional clinical competency certainly is a skill, but to exercise it well involves virtues such as honesty, integrity etc. MacIntyre (1981) develops the idea of a practice as providing a defining characteristic of a virtue.

[12] Carr and Steutel (1999) argue that virtues are teachable.

A second objection is that psychiatric professionals simply have no responsibility for the moral life of their clients.[13] This view would maintain that the aim of medicine is not to make people good but to make them healthy. This may well be true for most areas of medicine, but to recover from a mental illness does involve the exercise of virtues such as courage, determination, perseverance and the like. These virtues are discussed in the next sub-section.   c) Client recovery from mental illness involves acquiring or maintaining particular virtues. This section will make a case for particular client virtues as central to the recovery process. Most people who become mentally ill would like to recover. Traditionally, this has involved clients adopting particular virtues, namely obedience and passivity. These virtues, during the long clinical-expert ethos, were highly regarded by clinicians. The 'good' client during this period was a client who listened to the expert and did what they were told. Since the expert knew best, all the client needed to do in order to recover was to follow the 'profound instructions and prescriptions' of the expert. The clinician would be held responsible for the client's well being, but the client would be held responsible if they failed to follow the instructions of the expert to the letter. While such an approach has continued to lose favour, it continues to have a significant hold over clinical opinion and training and also over the view held by the general public. The reason for the continuing respect for such virtues as passivity and obedience within psychiatric services are complicated. However, one reason seems undeniable. Psychiatry as the dominant professional group within psychiatric services, has always modelled itself on medicine. In medicine, the role of the expert is still greatly respected. There continues to be much obedience and passivity from clients to medical intervention, which may or may not be a good thing. What it has meant for psychiatry is a similar desire to retain the role of the expert. However, there is a fundamental difference between psychiatry and medicine in that psychiatry deals with psychological dysfunction in terms of thinking, feeling, volition, perception, etc. and behavioural dysfunction as a result of the psychological dysfunction. Part of what heals these functions is that clients fully use them appropriately or start to fully use them appropriately. Blindly following instructions can never help clients to fully use these functions or take responsibility for their use.

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[13] Spicker (1977) argues that it is hubris of the worst kind for medical practitioners to directly affect their patients conduct or moral judgement through medical intervention, moral persuasion or education.

In what follows the virtues that clients need to recover from mental illness will be discussed.

Hope

The clinical-expert ethos rarely encouraged hope in clients. It was more concerned with an honest assessment of the clinician's view on the client's likely recovery. This could sometimes be very pessimistic or even fatalistic. The clinician did not really care what the view of the client was towards their prognosis since this was not an important part of treatment. Today, recovery from mental illness certainly does see hope as important. Unfortunately, hope has been proceduralised (because of the procedural ethos) and this has meant some of its essential nature has been lost. In a practical sense, for example, this can mean that discharge planning commences after a certain period, recording where the client would like to live or what they would like to do on discharge, as a way of creating hope. Discharge planning is an important therapeutic activity except when it is commenced simply because of procedural necessity rather than individual need.

Hopefulness is an important virtue in terms of recovery. Hope is defined as an expectation of a promising outcome. It is important because it gives the client the possibility that improvement will occur and that current problems will not continue. Hopefulness manifests itself in a number of different ways for the client: in their attitude towards self, others and the psychiatric service.

A hopeful client will see that their current situation is possibly temporary and that perspective will help them to accept it more readily. Acceptance of an illness is enormously important since the alternative responses such as unwarranted anger or denial are generally unhelpful for recovery.

A hopeful client will tend to see others as doing the best they can, even if currently they are not making much headway. This hopefulness that the right approach or treatment will be found tends to open the client to the world of possibilities and options which is important in a psychiatric context.

Also, a hopeful client will see the service as doing the best it can and once again, the client will be open to the possibility that the service will transfer their care onwards when or if that is appropriate.

Clients who are in despair about their recovery or who are unrealistically optimistic will tend to have a different set of attitudes. A client who is not hopeful but

more drawn to despair at their situation will probably experience more self stigmatisation since they will probably feel that their condition will continue and not necessarily change or improve. It is also probable that they will experience self-pity as a result of that self stigmatisation. Clients who are unrealistically optimistic (believing for example that 'this medication will fix all my problems') will often be disappointed as no miraculous solution is found. This can result in clients feeling angry with professionals and services in ways that are unhelpful.

Hopefulness needs to be an appropriate response to the given situation. There is a level of practical wisdom involved in not over- or under-valuing information but appropriately valuing it. This practical wisdom or assessment can sometimes be mistaken. Clients can be hopeful when the information and evidence suggest the outcome will not be a positive one. Hopefulness can still, however, be an appropriate response even if rationally the outcome is likely to be poor as long as the hope is tempered by a rational assessment of the likely outcome. Additionally, clients do need to establish collaborative relationships with professionals who can assist them to make good assessments of the likely outcomes.

Clients who are suffering from mental illness are often not able to rationally think through what degree of optimism would be 'appropriate' – at least in the early stages of the illness - and the very virtue of hopefulness can be undermined by their mental state, for example, in depression. Under these circumstances the professional has to be loyal, compassionate and able to assess the level of responsibility the client can take for their own well being.

Suffering, Self Awareness and Sympathy

Mental illness involves suffering. Severe mental illness can involve considerable and, at times, intolerable suffering. Suffering[14] is generally seen as an undesirable and unwanted experience but it can also offer an opportunity to develop particular virtues such as self-awareness, sympathy, trust and courage (which will be discussed later on). For some clients, suffering can be the first time they have had the time and opportunity to self reflect. In the early stages of suffering, during the acute stages, this reflection will be somewhat clouded reflection but later, as the acute symptoms subside, the client will probably start to ask themselves questions: Why

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[14] As Sujata (1976) indicates, suffering is viewed negatively, particularly because of the fatalistic view of thinkers such as Schopenhauer and Nietzsche.

me? Why now? Will I get better? Such self-awareness is important since it enables the development of the virtues of responsibility and self-discipline. Self-awareness can assist the client to recover in many ways: it can help them plan and organise goals, it can help them harness their own internal resources, and it can provide an important foundation for developing other competencies, skills and virtues.

Self-awareness of one's own suffering can often lead to an acknowledgement and response to the suffering of others. This can help clients to see that their own experiences are not unique but part of a common human experience. Such sympathy can often flow back to the client with the client being easier on themselves, less blaming of themselves, less likely to self stigmatise.

Such qualities as self-awareness and sympathy can help clients to trust themselves and, perhaps more importantly, trust family and psychiatric professionals. Sympathy helps the client feel human solidarity with the suffering of others. The trust arises through the client becoming aware that others are trying to ease their suffering rather than some other intention. Trust (as we will see) is essential for forming collaborative relationships with others and collaboration is an essential component of recovery.

Responsibility

When clients are initially admitted into a psychiatric service we might expect that they would have little responsibility for their own health or well being, particularly if they are admitted in a crisis state. Given that relatively high acuity levels are needed to trigger admission, all admissions will involve psychiatric professionals exercising significant responsibility.

Responsibility is a complicated concept. It can mean a variety of things. It can mean causally responsible for, as in 'the fire is responsible for burning the house down'. This is not the meaning used here. It can also be used to refer to moral blame or praiseworthiness in someone's choices. The concern is with this moral sense of responsibility.

Aristotle's conception of responsibility is helpful in making sense of how much we can hold someone responsible for their choices and under what circumstances. Though Aristotle did not see responsibility as a virtue, he did see it as a necessary condition for individual choices being considered virtuous or non-virtuous. Aristotle defined choice in the following manner:

> Since, therefore, an object of choice is something within our power at which we aim after deliberation, choice will be a deliberate appetation of things that lie in our power. For we first make a decision as the result of deliberation, and then direct our aim in accordance with the deliberation (NE Bk III 1112b26-1113a12).

Aristotle believed we could hold individuals responsible for their moral choices if they are made voluntarily. Mental illness could, under some circumstances, mean that someone's actions are not voluntary but compelled. This raises the issue of how much we can hold someone responsible for their moral character in light of non-voluntary actions. Aristotle introduces a distinction between full and qualified responsibility for one's character. While there is some disagreement among scholars about whether Aristotle intended to make a case for full or qualified responsibility for character, I tend to agree with Meyer (1993) who argues that Aristotle is making a case for qualified responsibility. It certainly appears that Aristotle is indicating that early moral education is vital and that someone who has not had such an education, or who has been exposed to bad role models, may be considered less responsible later in life than someone who has. Qualified responsibility then is responsibility lessened through someone's upbringing, education or experiences, whereas full responsibility is responsibility with no qualifications. This distinction between full and qualified responsibility is helpful when discussing responsibility for recovery since mental illness does not prevent clients from having moral responsibility. Responsibility is not a categorical concept but a continuum concept (as is recovery and mental illness) as we can have more or less of it. A client may not be able to take responsibility for some aspect of their life but be able to take responsibility for other aspects. Even within one aspect of their life there might be differing degrees of responsibility. Responsibility is not global but specific and particular. There can be qualified responsibility. For example, a client may be able to take responsibility for self-grooming but not able to take responsibility for administration of their medication. Even within self-grooming, the client may be able to take responsibility for some things but not others.

As clients move along the recovery journey towards mental health we would expect them to exercise increasing levels of qualified responsibility. The virtue of responsibility for clients then, is to appropriately assume responsibility for aspects of their health, as they are able to. To continue in a dependant relationship when able

to take more responsibility will not be conducive to recovery since the client will continue to function in an earlier recovery stage. Neither would taking too much responsibility early in the recovery journey be conducive to recovery, when the mental illness is seriously impacting on their ability to think and exercise appropriate judgement since, it is likely, that this will lead to poor decision-making.

Courage

Courage is necessary for recovery. Courage is defined as "a mean state in relation to feelings of fear and confidence" (NE Bk III 1113a6-29). In recovering from mental illness there is often a fear of the illness itself and also of the consequences of that illness for the client. In order to recover, a certain amount of courage to take decisions and live with the consequences of those decisions is needed. One also has to accept more responsibility for one's choices and have a more assertive role in restoring one's health. There is also the fear that some choices may make the illness worse.

In the initial stages of the illness it can take courage simply to stay with the illness experience rather than to commit suicide, for example. Later, as more acute symptoms dissipate, the client needs to have courage to take the next steps for their recovery journey. The client increasingly needs to make decisions for themselves and take responsibility for those decisions. Without the courage to take the next step, the client may well find themselves 'stuck' at a certain stage of their recovery. Life skills, social skills and self-perceptions are all elements that are affected by mental illness but that will not improve without the client having the courage to take the next step. Cowardice could be considered a recovery vice. Its presence will actively undermine the recovery journey of the client and perpetuate a continuing sick role. Such cowardice needs to be contrasted with another recovery vice, namely lack of fear (or impulsiveness). A client who fearlessly attempts to take responsibility for aspects of their life that they are not ready for, will more likely than not fail and their recovery will be set back. The right point to exercise courage will be discussed as part of the recovery narrative in Chapter 8.

Perseverance

For the client who has taken some responsibility for their own health and their own recovery journey and who has shown courage in taking the next recovery

step, it becomes pivotal that they are able to persevere in their recovery journey. Perseverance is the virtue of sticking with something for the attainment of some desirable goal. Recovery from mental illness can be a long process. It will be longer if the client has had the illness for a long time. The ability to stick with the recovery journey and the consequences of this in terms of accepting more responsibility and accountability for one's actions becomes very significant. If the client cannot stick with the recovery journey, it will have a tendency to mean they either get stuck in their current recovery stage or alternatively that they regress to an earlier stage.

If a client fails to make progress due to a lack of perseverance, it is more than likely that they will turn to either family or psychiatric professionals to help them to get moving again. The problem is this will prevent clients taking responsibility for these matters for themselves. This may not be important if it is for a short period of time, but, if the period is extended, this could have repercussions for the whole recovery journey.

If a client regresses, this obviously has implications for the client's recovery. At its most serious, this might involve a relapse where the client moves back towards a crisis stage of their recovery journey.

There are times when a client cannot persevere due to their illness. It is important to distinguish between these occasions and occasions when the client can persevere but chooses not to. There is also the indeterminate case where it is unclear whether the client was unable to persevere because of their illness or because they chose not to. It is important to err on the side of caution in these indeterminate cases and assume that the illness has had a significant role since otherwise there is a danger of prejudice by professionals interfering with the client's journey.

Perseverance needs to be contrasted with stubbornness and fickleness. Stubbornness is a tendency to stick with something even when it appears that sticking is counterproductive. Perseverance is a rational activity. It involves sticking with something because it helps to realise some goal which is viewed as valuable. Recovery of mental health is certainly such a goal. Alternatively fickleness is a tendency (or vice) of constantly changing and not sticking with anything. In a recovery context this might, for example, involve trying many different options for treatment and even when one is found that appears to work, still wanting to try something else.

Collaboration

Collaboration is a virtue of being able to work with others. In psychiatric services this is a vital virtue for both clients and psychiatric professionals. There will be further discussion about a model of practice based on collaboration in Chapter 7. For the client, collaboration with psychiatric services is often difficult. This is because traditionally psychiatric services have not been collaborative, nor was that even attempted. They have been heavily paternalistic. For those clients who have been in the system for a long period of time it is, therefore, hard to trust that collaboration is anything but symbolic and tokenistic (or simply collaborative behaviours). Even for new clients, the old images of paternalism are very much still around. Collaboration rests on an assumption of mutual respect. Clients really need to respect that psychiatric professionals have something to offer and psychiatric professionals need to respect that the journey of recovery, as experienced by clients, also offers a certain expertise (I will discuss this in Chapter 8). As shown in Chapter 2, the recovery criteria involve improvements to symptoms and functioning that are meaningful to clients and professionals. The only way that both groups can comprehend "what is meaningful to the other" is through collaboration. While there are different models of collaboration, they all share a concern to ensure that the important aspects of someone's recovery receives input from professionals and clients, thus preventing either purely self directed care from the client or paternalism from the professional.

The ability to collaborate involves a number of mental functions: judgement, insight, cognition, feeling, volition, etc. When someone is very ill, some or all of these functions will be affected in such a way that the ability to collaborate will be compromised. Under these circumstances, all that professionals can do is use their clinical wisdom and model collaborative practice and hope that the client's symptoms and functioning improve to the extent that they are able to participate more actively in the collaborative relationship.

Honesty

In order to be collaborative, honesty between client and professional is essential. If clients are not honest about their experiences, particularly their experience of mental states, it will be difficult for any meaningful dialogue to occur with psychiatric professionals or others. As for collaboration between client and professional, there is an historical legacy that makes honesty between them less easy

than it otherwise might be. Until quite recently, the hard paternalism of psychiatric services meant that clients who were very honest about their experiences, in terms of symptoms, would receive longer periods in hospital and be subject to more assertive treatment. In such an environment, to be discharged required not honesty but skills of persuasion; the skill of persuading the professionals that all was well. Honesty is the virtue of telling the truth. For a collaborative model to work, honesty is imperative. Lying or deception inevitably means that not all the relevant information for making informed decisions is available. In order for clients to move on in the recovery sense, they need to be honest with themselves as well as with others. Self-honesty involves accepting problems as they are according to the evidence. If someone is in denial of their illness, for example, it makes it difficult to achieve any kind of honesty.

Self-discipline

At some point in their recovery journey, clients become aware of what helps them to recover. This is often hard won information, the result of perhaps several relapses. This information, if used well, can help them to identify early warning signs so that they can prevent the worst aspects of their illness taking hold again. This early warning information can be built into a wellness maintenance programme. To continue with a wellness maintenance programme involves considerable self-discipline. It is this virtue of self-discipline that is so necessary for clients who want to recover from mental illness. This kind of self-discipline cannot be given by someone else and no one else can take responsibility for it. Self-discipline involves perseverance and honesty, since clients need to stick at it and honestly admit to themselves if they are failing in that task. For example, it might be the case that a client knows that they are vulnerable to the use of marijuana and that using it increases the risk of the symptoms of their illness manifesting itself. Continuing in their recovery means they need to stop using marijuana. Since marijuana has addictive properties this is a difficult goal to accomplish, though necessary for recovery.

Practical Wisdom

In Aristotle's terminology, all the previous virtues are considered moral virtues. At some level these moral virtues are about emotional balance (that is exercising rational control over and directing the emotions) whereas the intellectual virtues are about thinking. We must now turn to the intellectual virtues, or more

specifically practical wisdom, and its significance for recovery. Intellectual virtue can be seriously affected by mental illness, even more so than moral virtue. Illness can involve perceptual and cognitive distortion; and therefore insight, judgement and reasoning capacity must be considered when deciding on a client's capability. However, it is unusual for clients not to recover these mental functions to some extent, at least sufficiently to be able to understand the implications of their absence. Once again, intellectual virtues such as reasoning, practical wisdom and deliberation are on a continuum with clients in a crisis state not able to exercise these virtues with any degree of consistency and then slowly regaining them over time as they move towards self-care.

Everyone has different innate capabilities in terms of the intellectual virtues, which can be developed or not by education. In that sense, recovery of intellectual capabilities and virtues will be different for each person recovering from mental illness. There is no one fixed point that everyone is aiming at. Each client journey will be quite different. Practical wisdom is a key concept for understanding the virtues in clients recovering from mental illness. It is also a complicated and contentious area of Aristotelian enquiry. For Aristotle, practical wisdom means to be good at thinking about what one should do. For a client recovering from mental illness, that means being good at thinking about what one should do in order to recover from mental illness. The key notions here are that thinking (itself a universal concept applicable in many contexts) needs to be applied by a particular client recovering from mental illness. Additionally, practical wisdom seems to be concerned with both means and ends. The other key point is that what one 'ought to do' is meant to be seen in a very specific way in the Aristotelian tradition of understanding the virtues. These three key points about practical wisdom will be discussed one by one.

Thinking – like mental illness or even like recovery- can be seen in universal terms applying to many different types of people and contexts. This type of universal thinking has been instrumental in producing the diagnostic manuals used to diagnose mental disorder. Aristotle himself differentiates between this universal or scientific thinking and the practical thinking that must deal with particulars. It is this client at this particular time who needs to make decisions about their recovery. The need to deal with particulars is one of the reasons why abstract principles and procedures often fail to assist with complicated decision-making at an individual level.

Aristotle develops a teleological account concerned with relating concepts such as nature, function and purpose to the notion of the good life. As Aristotle notes, "every art and every investigation, and similarly every action and pursuit, is considered to aim at some good. Hence the Good has been rightly defined as 'that at which all things aim'" (NE Bk I 109421-22). So every human action has its own aim or object. These objects in turn are means to yet other ends, and so on. To give a basic example; a client may attend a group therapy session in order to recover the ability to relate to others. This ability to relate to others may enable the client to get a job. Securing a job means he has an income with which he can go on holiday. It may be that the client would choose none of these things for themselves alone. He may dislike groups and not enjoy working in a job. However, the end which he does accept for itself affords the motive for the intermediate ends that are necessary stages in the progression to the final aim. But equally, to revert to the first step in the process, he may attend the group therapy session simply because he enjoys it. Or he might enjoy it and recognise that it is a step towards something else that he finds desirable in itself. But, however long or short this chain of activities may be, there must be at the end of it something that is sought after for itself alone and not as a means to something else. Aristotle would maintain that even beyond the end of recovery from mental illness there must be a supreme good (*eudaimonia*) towards which all human activities are directed.

When Aristotle speaks about what we 'ought to do', he is using this phrase 'ought to do' in a very particular way. Moral terms for Aristotle have a broader sense than we tend to use today. We tend to think of moral decisions as decisions that affect others. Aristotle is using such commands as "I should eat healthy food" and "I should take my medication" as moral statements. So, for example, a client should take more responsibility for their own health as they improve and this will involve taking decisions such as when to see psychiatric professionals less often, when to decrease the amount of medication they are taking, and when to take responsibility for self administering their medication.

In broad terms, these characteristics of practical wisdom in the context of recovery can be seen to apply to the following stages of the recovery journey: crisis, rehabilitation and self-care.

In the crisis stage, the only opportunity for displaying practical wisdom might be for the client to realise that they should defer to psychiatric professionals.

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Assuming a client is able to make this decision, they will need to trust that psychiatric professionals have their best interests as their prime motivator, not making money or passing exams or any of a multitude of other motives. This moral virtue of trust is consequently foundational for the realisation of other virtues. It also demonstrates, as Aristotle would agree, that at some level the virtues form a unity.

In the rehabilitation stage, the client displays practical wisdom by realising they need to take increasing responsibility for their own mental health but collaboratively with psychiatric professionals. Pragmatism is concerned with clients making as many decisions for themselves as they can and taking responsibility for them, with psychiatric professionals providing a therapeutic safety net. Courage is an important moral virtue for helping the client to rehabilitate. It has significance at all points in the client's recovery journey but it is particularly relevant in the rehabilitation phase where there is a tension between illness and health conceptions.[15] The sick role can be difficult for clients to let go of, and if they have been in that sick role for an extended period of time it can be particularly difficult to move on from it since it becomes comfortable and predictable. Courage is needed to let go of that sick role with all the implications of such a role in terms of the amount of responsibility someone can exercise in finding work or educational qualifications. It is practical wisdom that ensures that a client uses appropriate courage to become unstuck and take the next step.

In the self-care stage of recovery, practical wisdom is displayed when clients accept increasing levels of responsibility for their own mental health in terms of their wellness maintenance programme, with psychiatric professionals deferring to the client's decisions.

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[15] Rehabilitation is often seen as a phase in the recovery journey characterised by tension between illness and health, as the acute symptoms subside. The tension results from a need to keep symptoms under control while pursuing healthy activities such as work, relationships and personal interests.

Summary

This chapter has indicated why the virtues offer a way of understanding how recovery can be facilitated by psychiatric professionals for clients suffering from mental illness. Virtues are useful in this sense because, like recovery itself, they are concerned with inner growth and development. A conception of the virtues based heavily on Aristotelian foundations offers the best way of conceiving of the virtues.

In order to ensure the best prospect of recovery, clients who are suffering from mental illness need to acquire or develop a sense of hopefulness about the possibility of recovery. They need to build on the experience of suffering to develop virtues such as self-awareness, compassion and trust. Without these virtues it will be difficult to accept or acquire the virtue of accepting increasing levels of responsibility for their own well being. In order to do this, they need the virtues of courage, perseverance, honesty, self-discipline and a preparedness to be collaborative in their dealings with psychiatric professionals. In the Aristotelian sense, these virtues can be seen as moral virtues. Clients also need to acquire the intellectual virtue of practical wisdom without which they will find it difficult to assess what is the appropriate time to accept increasing levels of responsibility.

For their part, the psychiatric professional also needs to develop or acquire virtues. Professionals who want to be therapeutic agents in the way they assist clients to recover from mental illness, need the virtue of being able to let go of responsibilities so that clients can assume those responsibilities. Psychiatric professionals also need to be loyal to clients since recovery takes time and frequent changes of clinician can have a destabilising effect. Psychiatric professionals need to be people who have sympathy and compassion for clients who are mentally ill. Indeed, without the virtue of sympathy they should not even think about a career in this area. Psychiatric professionals (like professionals in any field) need the virtues of genuineness and integrity. Since recovery can take a long time, they need to be patient and able to wait for the appropriate moment before making interventions. They need the virtue of tolerance and the capacity to be collaborative with clients. As an intellectual virtue, psychiatric professionals need the virtue of practical wisdom to know when to step back and facilitate a client's assumption of responsibility for an activity or function (or the wisdom to know when to take on more responsibility).

The next chapter will consider what is the best virtue-based collaborative model for client-professional interactions.

CHAPTER 7

The Recovery Ethos Part II: The Collaborative Client-Professional Model

Chapter 6 indicated the virtues that clients recovering from mental illness need to acquire or develop if they are to be successful in their recovery. It also indicated the virtues that psychiatric professionals will need to acquire if they are to be therapeutic agents (or healers).There is a significant overlap between the two sets of virtues and so there is a sense in which the way the client and professional relate to each other can either reinforce or undermine the virtues they need to acquire. We should now consider the nature of the interaction between clients and professionals. As will be argued in Section Four, only the collaborative model provides a basis for fully reinforcing professional-client virtues.

This chapter has four sections. Section One will critique three models of client-professional interaction from past and current practice that have attempted to address the issue of how clients and professionals should interact in psychiatric services. Section Two will critique a fiduciary-based model from Pellegrino and Thomasma (1981, 1988) that has been applied to health. Section Three will indicate some modifications of this fiduciary model for psychiatric practice. Section Four will present the collaborative virtue-based model.

Section One: Critique of Models of Client-Professional Interaction

The aim of this section is to critique three models of client-professional interaction which have been used in psychiatric services. There are three models of client-professional interaction that have had historical traction in psychiatric practice and that continue to have exponents. These models are: the expert care model, the rights-based model and the contractual model.[16]

The Expert Care Model

The expert care model was developed during the clinical- expert ethos. It is a model characterised by a high degree of paternalism and based on the notion that the professional, usually a medical doctor, knows best. The perspective of the client (who

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[16] While Pellegrino and Thomasma (1981, 1988) offer some discussion of these models, Oakley and Cocking (2001) offer a sympathetic treatment of virtue-based models.

was referred to as a 'patient' during this period, that is, someone who was passive and non-assertive) was seen as unimportant compared to the expert's view. However, for all its many defects, this model was grounded in an earlier Hippocratic view of the doctor as having a strong duty of care towards their patient, a duty of care in which the doctor was held to be responsible. A central problem with this model was that it relied absolutely upon the expertise of the doctor (or other health professional) and not at all upon the client's expertise. Also – particularly during its highpoint in the late Victorian period – it was not interested in the way in which the professional and client interacted. It saw the expert's role almost in technical terms as a vehicle for mechanically rectifying structural defects in the client's brain. This was particularly true for experts who based their work on a biological approach to care. However, similar concerns were also apparent for psychoanalytically oriented professionals, who saw their role as interacting with the client so that they could make a correct interpretation of the client's psychological processes.

The Rights-Based Model

Largely because of the paternalistic excesses of the previous expert care model there was an increasing recognition of client rights. These rights were enshrined in legislation and increasingly in procedures. This approach, while of historical origin, is still very much with us in the procedural ethos, which has come to characterise the underlying philosophy of psychiatric services. The rights-based model was characterised by an increasing emphasis upon the self-determination of the client and the need of psychiatric services to respect the client's choices and decisions. The previous expert care model was often demonised by proponents of this model. While this model certainly led to increasing tolerance and respect for client autonomy, paternalism was often seen as being untherapeutic. The rights-based model was not, in itself, concerned with the nature of the relationship between the client and professional, only with ensuring that the client's rights were not violated. There tended to be an emphasis upon client rights and not a corresponding set of rights for psychiatric professionals, who had all the responsibilities for protecting client rights but few of the benefits. The anxiety associated with violating client rights has tended to make services focus upon the minimal requirements to ensure no legal redress and yet this may involve doing less than would be desirable.

In psychiatric services a rights-based model is particularly problematic since there are occasions when the Mental Health Act can be, and needs to be, invoked with some justification: that is, for clients clearly a risk to themselves or others because of their mental state. In a rights-based model of care, if the client is not able to exercise their own rights those rights are codified by a set of procedures where principles are enshrined in protocols, guidelines and policies and pre-eminently in legislation. As already explained, relatively small numbers of clients, at any time, require the Mental Health Act and yet the procedures designed to ensure that their rights are respected are transferred onto the majority of psychiatric clients, just in case they become unwell and need the Act.

The rights-based model has also tended to mean that the responsibility that existed during the clinical-expert ethos has shifted from the professional to the guidelines and procedures. At times this has led to frustration for clients who are subject to abuse as they try to battle against a 'system' to prove their rights were violated. The rights-based model required that professionals behaved in a certain way because these were the rules. This has led some clients to have a sense of entitlement and also, perhaps more seriously, it has led to professionals and clients not trusting each other.

As clients tried to obtain their rights, some professionals were starting to see that it was usually the paternalistic decisions to withhold information or to put clients on a new medication without consulting them that created problems, rather than, for example, omitting to involve clients in a graduated way to assume more responsibility. Rights are categorical, one has them or one does not. There has been (and continues to be) a tendency for some professionals to see rights in a black and white way. Either clients are or are not allowed to make decisions for themselves. If they have a right to make decisions for themselves, then there are no intermediate cases in this analysis. The reality is that there are many intermediate cases or shades of grey, which are often not captured in a rights-based approach.

The Contractual Model

The rights-based model has underpinned the development of the contractual model. The contractual model is fundamentally about the client and professional agreeing to a set of conditions and forming a contract for their mutual encounters. The contractual model accepts that the client has a number of pre-existing rights and that

the contract cannot alienate these. The problem is that the contractual model assumes a high degree of client competency and understanding in order to be able to agree a contract with a professional in the first place. In practice, there is always a significant imbalance in power and understanding which makes contracting difficult.

The contractual model, not surprisingly, is popular in private practice. Psychiatrists such as Szasz are particularly enthusiastic about such a model. Outside of private practice, however, it is difficult to see how contracting can occur in any sense that is credible. For a client arriving in a psychiatric service during a time of crisis, it simply makes no sense to expect that they would formally contract with a psychiatric professional.   Contracting involves a significant amount of negotiation. It is far from clear that in a non-private context such negotiation is possible for all clients for all their admissions. Contracting might be possible during the partnership phase of collaboration, but even then, a contract simply based on rights would be a very thin contract indeed.

Section Two: Critique of Pellegrino and Thomasma's Fiduciary-Based Model

The aim of this section is to critique the 'fiduciary' model of client-professional interaction developed by Pellegrino and Thomasma (1981, 1988) for a health context.

'Fiduciary' comes from the Latin and means 'in trust'. This model is based on a richer and more complex understanding of human relationships, which appeals to the older tradition referred to in the expert care model, namely a model where the health professional offers a service based on agreeing to put the client's interests first so that the professional can 'hold in trust' the client's wellbeing. This older tradition was taken in an extreme paternalistic direction under the clinical-expert ethos, which is partly why it fell from favour for a period. The fiduciary model, which has regained popularity in recent years, appeals to the virtues in a more Aristotelian sense. There are a number of fiduciary-based models but perhaps the best known is the beneficence-in-trust model developed by Pellegrino and Thomasma (1981, 1988).

Pellegrino and Thomasma put forward their beneficence-in-trust model as a way of avoiding the pitfalls of either an autonomy-based model or a paternalism-based model. In an autonomy-based model (such as the rights-based model discussed earlier) the client is seen as being the important decision-maker, who simply seeks the opinion of clinicians. The autonomy-based model, however, often fails to

acknowledge the significant power imbalances that currently exist within healthcare. The autonomy-based model is also not well suited to the psychiatric context, where the very capacity for independent decision-making can sometimes be affected. The paternalism-based model (or expert care model) is also limited. It might be argued that for individuals who are unable to exercise their own decision-making faculties or functions, the role of professionals to paternalistically make decisions for the client becomes warranted and justified.   However, – if we accept that there might be occasions when some degree of paternalism is justified – there is still the problem of adapting such interventions for clients who are able to make their own decisions[17]. This capacity is violated by professionals acting paternalistically, even if they are doing it for what they perceive to be the best interests of the client. This represents a major problem for the paternalism-based models and hence the need to find a model that does not have its weaknesses.

The beneficence-in-trust model of Pellegrino and Thomasma (1981, 1988) is a more subtle model than either the autonomy or paternalistic models. In this model, Pellegrino and Thomasma reach back to older forms of relationship between the health professional and client. Their focus is on the relationship between doctor and patient but the essential characteristics of their approach can be broadened to include other professionals. The beneficence-in-trust model is essentially a fiduciary-based approach based on relationships that appeal to the virtues of both client and professional and is primarily motivated by the client's best interests. While both client and professional have responsibilities in this regard, the professional has the prime responsibility since there is the power imbalance in terms of knowledge and skills mentioned previously.

Pellegrino and Thomasma believe that a reinterpretation of the principle of beneficence is fundamental to the business of developing a new model. By beneficence they mean a complex concept that has a number of levels. They believe non-maleficence is its basis, which is to do no harm (a principle enshrined in the Hippocratic oath). The next level is to prevent harm to others. As Pellegrino and Thomasma (1988) say "here we move from a passive non-maleficence to a more

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[17] There is an extensive literature indicating the ethical justification of paternalism in psychiatric services under some circumstances, for example Lavin (1995) argues that civil commitment is justifiable under strict conditions. However one of the problems with such conditions, as Culver and Gert (1978) reveal in their own work, is that such conditions can easily become procedural and thus

active interpretation on behalf of others" (p.26). It is this positive act which is more problematic since, in actively attempting to prevent harm, there is the possibility of acting paternalistically. For example, in the case of the client who has a history of self harming the professional decides to require that medications be dispensed weekly. This will inconvenience the client since they will need to come in to collect their medication on a weekly basis but it may mean they do not have the opportunity to self harm on medication. We might agree that for some clients such a level of paternalism is warranted but as a general rule feel it will depend on the particular mental state of the individual.

Pellegrino and Thomasma (1988) see the autonomy-paternalism split as unhelpful in terms of developing the beneficence-in-trust model, which is why they have sought to conceive a new understanding of beneficence[18]. They see beneficence – our degree of sensitivity to the good of others – as comprising elements of both autonomy and non-maleficence in that they do not see paternalism as part of beneficence (as Beauchamp and Childress (1994) do, for example).

Their beneficence-in-trust model has six key features. It is beneficent, the existential condition of the client is paramount, it has no automatic ranking of values, it is predicated on consensus, it has a prudential moral object, and it is axiomatic (pp. 32-33).

The aim of medicine (or health care) is beneficent in that in healthcare we are responding to the distress and suffering of the client as a prime driver. They see this as having three components: a) the client's problems take precedence (ordinarily) over everything else; b) harm must be avoided since intentional harm would prevent them relieving the distress of the client; and c) both autonomy and paternalism are superseded by the obligation to act beneficently.

The primacy of the existential condition of the client is paramount, by which they mean such aspects as the client's ability to make rational choices about care, the nature and past values of the client, the client's age, the nature of the illness and the clinical setting.

There is no automatic ranking of values in the beneficence model, which contrasts with autonomy and paternalism models where either the client's right to

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potentially inflexible as a form of practical decision making if we rely on them in a final decision-making way.

[18] In Section Three the differences between beneficence and benevolence (the virtue) will be clarified.

choose or the ability of the professional to know what is right is elevated to the primary value. Each client must be treated as an individual and therefore only the value of acting in the best interests of the client are non-negotiable; everything else has to be negotiated between the professional and the client. As Pellegrino and Thomasma (1988) state, "This model requires that patients and physicians become able to identify, rank, discuss and negotiate values" (p. 33).

The beneficence model is predicated on consensus between health professionals and between professionals and client.

Having a prudential moral object is another key feature, by which is meant that difficult ethical quandaries must be settled by attempting to preserve as many of the client's and professional's values as possible.

Axioms are the sixth key feature. Pellegrino and Thomasma (1988, p.34) believe that in order to avoid the pitfalls of situational ethics or the autonomy/paternalism models it is necessary to have a number of generalised axioms to guide health practice.

In the next section I will indicate how this model needs to be modified if we want to use it in a psychiatric context.

Section Three: Fiduciary Model Modifications for Psychiatric Practice

The aim of this section is to show how the beneficence-in-trust model needs to be modified in order to make it appropriate for psychiatric services. The Pellegrino and Thomasma model is a significant attempt to embed the client–professional relationship in the virtues rather than principles or rights. The model has much to recommend it, particularly in general healthcare. While the model was not developed specifically for psychiatric services, at no point in their argument do they attempt to exclude psychiatric practice and hence we can only assume they meant to include it. However, there are a number of serious problems with adopting the model as represented directly into psychiatric practice. Insofar as it attempts to make the case that paternalism has no part in beneficence, the model is based on a mistaken understanding of beneficence.

Paternalism is a more serious issue in psychiatric practice than it is in other areas of healthcare since, in psychiatric services, it is more prevalent for clients to lose the functional capacity to make decisions and exercise reason in their own best interests. There is a wide consensus that under strict circumstances it is warranted and

justifiable to override the client's own wishes if these appear to be at odds with their real best interests due to mental illness. Since Pellegrino and Thomasma (1988) define beneficence as the sensitivity to the good of others, it would appear that acting paternalistically (even when it is warranted and justifiable) is not being sensitive to the good of others. However, this would seem to be a mistake. While secluding clients, treating them against their wishes and placing them on a section of the Mental Health Act preventing them from leaving the mental health unit can be portrayed as coercive, it can also be seen as life saving and as acting in the real best interests of the client. The client who, while depressed, requests to be allowed to walk on a high bridge has clearly expressed a wish. However, most people would accept that being sensitive to this person's true good would involve declining their request, however diplomatically. As previously mentioned, when we see beneficence as more important than non-maleficence, it inevitably involves the question of preventing harm in a way that might have paternalistic overtones. There will be a matter of degree in that the purpose of overriding a client's wishes must be to prevent significant harm that cannot be achieved using other methods[19]. In a psychiatric context, it is important to see that paternalism is justified and warranted under certain circumstances and that it is about being sensitive to the good of others but also about being able to act benevolently for the client's good[20].

A second problem arising from the first is that Pellegrino and Thomasma (1988) see consensus as pivotal to their model. However, they make little allowance for the competency needed to make consensus happen and the way competency can be assessed. There are different tests for assessing competency. Roth et al. (1977, pp. 279-84) identifies five tests for assessing competency: a) evidencing a choice; b) reasonable outcome of choice; c) choice based on rational reasons; d) ability to understand; and e) actual understanding. The first test is very elementary and is probably only relevant to clients who are unconscious for whatever reason. The second test considers whether the outcome is reasonable given the person's

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[19] Johnson (2002) has a useful account of the standard of decision-making capacity to be applied; as she says: "In other words, the extent to which an attending health care professional is bound morally to respect the choices of a person deemed 'rationally incompetent' depends primarily on the severity of the risks involved to the patient if her or his choices are permitted. The higher and more severe the risks involved, the higher and more rigorous should be the standards for determining the patient's decision making capacity, and the more certain attending health care professionals should be that the patient has met these standards" (pp.228-229).

[20] Acting benevolently, for the client's good, is not an absolute even with people deemed incompetent as Van De Veer (1986) has shown.

circumstances. The third considers whether the choices people make are based on rational reasons. This involves assessing whether the reasons people adduce for their choices make sense within their context. There are times when, due to mental illness, a client may not have rational reasons. The fourth test considers whether clients have the ability to understand their options and the proposed course of treatment. The fifth test considers whether clients actually understand the options and treatments available.

These five tests can be seen as forming a continuum towards a more exacting level of assessment in that the actual understanding of their options and treatments is a significantly higher threshold for a client than the ability to evidence a choice. The point of this is that consensus (like collaboration, which will be discussed later) relies on a certain competency. The crucial issue that we need to be clear about is how we are determining competency, since the result would be quite different depending, for example, on which of the previous five tests we use. It is quite legitimate to say that consensus can be achieved along the client's recovery pathway from crisis to self help, provided we indicate that we are using a particular competency test. Brock and Buchanan (1989) make the important point that competency is a competency about a particular action and that therefore we need to clearly identify the choice and action we are referring to, rather than a global conception of competency.

Consensus is not always possible, even when people are mentally well. Consensus can be very problematic when individuals are mentally ill. Therefore, I prefer to talk about agreement between client and professional rather than consensus, since this indicates a particular collaborative outcome. Consensus, as we have already seen, can easily lend itself to a procedural mentality, which is something I am trying to distance myself from in this thesis.

The third problem with the beneficence-in-trust model as presented by Pellegrino and Thomasma is that the axioms they state are not practically helpful in a psychiatric context and can be seen as implicit within a virtue-based model. The four axioms they state are: 1) both doctor (or health professional) and client must be free to make informed decisions and to act fully as moral agents; 2) physicians have the greater responsibility in the relationship because of the inherent inequality of information and power between themselves and those who are ill; 3) physicians must be persons of personal moral integrity; and 4) physicians must respect and

comprehend moral ambiguity yet not abandon the search for what is right and good in each decision. As will become clearer in the next section, the problem with these axioms is that they provide a specious procedural appearance to things best handled in a virtue approach, since these axioms provide no substance for assisting with practical decision-making over and above the values implicit in the virtues that clients and professionals need to have developed. The virtues of integrity and the virtues connected to responsibility, honesty and collaboration cover these axioms.

Section Four: Collaborative Virtue-Based Model

The aim of this section is to present the collaborative virtue-based model. Collaboration and partnership are currently buzz words in psychiatric practice. Everybody wants to be collaborative. Unfortunately, the reality and the intention are poles apart. This is because collaboration necessarily relies on a virtue-based approach, which is sadly missing from current psychiatric approaches.

Collaboration, as already seen, involves the client and professional working together. My contention is that it is only when that working together is founded on a virtue-based approach that collaboration is possible. Other approaches, relying on principles and rules, may appear to involve collaboration but the reality is that the principles and rules always bias the process towards the professional. Much of what passes for collaboration is best referred to as consultation.

This section will describe the main components of the collaborative model which is loosely based on the beneficence-in–trust model already described. The collaborative model is a model being proposed as an ideal model for psychiatric services. This will be done, firstly by providing a rationale for the collaborative model; secondly describing the components of the collaborative model; thirdly by indicating the major features of the model; and fourthly by giving some practical implications of the model.

Firstly, as already discussed, collaboration is the virtue of being able to work with others and this involves sharing both moral and intellectual virtues: the moral virtues are honesty, integrity, perseverance, sympathy and the like; the intellectual virtue is practical wisdom which both the professional and client can bring to the encounter; and by sharing the technical expertise that both possess. For the professional, this expertise is knowledge and skills in diagnosing, treating and researching mental disorder and mental illness, whereas the client brings an expertise

in their own experience of mental illness which can help them recover. Together, this collaboration is a powerful combination since neither the professional nor the client has a complete picture of the situation by themselves, but in combination there is the potential for a more complete understanding. Collaboration is also a matter of having the appropriate collaborative attitude. Both the professional and the client need to really value and respect the expertise of the other. If either or both are full of their own hubris in terms of believing their contribution is more important ultimately than that of the other, the possibility of meaningful collaboration is much reduced. This attitudinal respect is quite different from seeing that, at various phases of the collaborative relationship, either the client or professional can have more to contribute. The collaboration is ultimately focused on the good of the client and this provides its foundational purpose.

Secondly there are a number of components to the collaborative model: a) fiduciary base; b) phases of collaboration; c) attempts to reduce or eliminate 'ethical dissonance'; and d) processes for dealing with differences between clients and professionals.

a) The model has a fiduciary base in that the client's well being is 'held in trust' by the professional. The virtues of both client and professional pertinent to recovery from mental illness are both potentially optimised by a collaborative model in that they are both working on the same project for the same purpose, namely the good of the client in terms of their recovery from mental illness.

b) As previously discussed, the collaborative model accepts that for collaboration to occur there needs to be a certain level of competency in the client and, given the focus on recovery, a shifting emphasis on professional and client responsibility. In the early phases of the encounter, the responsibility is predominantly the professional's (although this will depend upon competency assessments and even in the earlier phases the client may be deemed responsible for aspects of their own well being) and this can become true partnership during the rehabilitation period of the client's mental illness, where there is an increasing emphasis upon wellness in addition to illness. Finally, the later stages of collaboration involve the client assuming increasing levels of responsibility for their own wellness.

c) The term 'ethical dissonance', relates to the differing perception between the professional and client with regards to what the client should do for their recovery and hence the level of responsibility a client can safely assume for their recovery.

Collaboration is the virtue of being able to work with others. It can be seen to involve a collaborative attitude and a collaborative expression of that attitude in collaborative behaviours. Where the disagreement between client and professional is great, the possibility of a collaborative behaviour is lessened; where the disagreement is small, the possibility of collaborative behaviour is increased. While the collaborative behaviour is affected by disagreements, the collaborative attitude from both client and professional needs to be strong at all times. There will be periods, particularly in the initial stages following admission, when for clients who are incompetent in terms of their reasoning, memory and judgement skills and who have some perceptual disturbance, the likelihood of collaborative behaviour is small. Under these circumstances, the professional needs to ensure they retain a collaborative attitude but accept that due to the client's capability, most of the decisions will be taken by the professional and so the decisions will be professionally determined. However, as the client's competency increases, their capability improves and hence their involvement in decisions affecting them also increases. During the partnership stage of collaboration, the client's own journey (and the story clients tell themselves about that journey) becomes an increasingly determining factor.

d) Ethical dissonance can usually be managed, but sometimes the level of disagreement is so large that a process of resolution is necessary. In the first instance, the client's own wishes for their life, based on their values and concerns should be the predominant feature, unless there is compelling reasons for believing the client is unable to articulate these in their own best interests. If a client is currently psychotically disordered, for example, the professional is obligated to try and discover what is in the best interests of the client, based on the client's values and advance directives by conducting discussions with the client, their family and friends, etc. It is in this area that the idea of collaborative phases is particularly useful since it can guide professionals as to their responsibilities. However, where necessary, the professional needs to consider substituted judgements as a next possibility; involvement of a clinical leadership team, a reviewed opinion from another service, a regional ethics committee and finally the legal system in ascending order are ways disagreement can be handled to resolve disputes that cannot be resolved within the client-professional relationship.

Thirdly, these components of the collaborative model have a number of features: a) a beneficent aim, b) values that are negotiated, c) optimisation of virtues, d) principles, and e) the valuing of expertise.

a) The aim of the collaborative model is a beneficent one as it is in the beneficence-in-trust model, namely the good of the client. This does not imply that other aims will not be present – such as the need for services to account for spending, for example – but only to say that the dominant aim needs to be the beneficent one.

b) The collaborative model does not assume – as do expert care models or rights-based models - for example, that ultimately the values of the client or the values of the professional should dominate. In the collaborative model, the values are negotiated between the client and the professional. This negotiation can be more time consuming than models that automatically defer to either the client or the professional, but what it loses in terms of time it gains in terms of acceptability.

c) The model provides an opportunity for the optimisation of the virtues for both clients and professionals. It does this by focusing on what is the good of the client in terms of their recovery from mental illness and hence the virtues which professionals need in order to assist clients with this journey – mentioned in Chapter 6 Section Two – and the virtues needed by clients in order to recover from mental illness mentioned in Chapter 6 Section Three, are mutually reinforcing.

d) Moral principles, that are internally generated by the 'community of interest' in psychiatric services can be of assistance to professionals and clients alike. The key point is that these principles are not imposed but negotiated collaboratively by the professionals and clients involved. How this negotiation can occur will be further discussed in Chapter 9 when we discuss the psychiatric community.

e) This collaborative model is premised on the assumption that both professionals and clients have a particular expertise, which neither possesses alone. This expertise, if harnessed through mutual sharing, respect and valuing, can provide clients with the opportunity to recover.

Fourthly, there are practical implications to using the collaborative virtue-based model. This model rejects the simplistic approach of the autonomy-paternalism dichotomy which has dogged psychiatric practice for much of its history and also the current focus upon the dominant principle of justice. By emphasising the need to reduce ethical dissonance and to increase consensus and negotiation, the model does not distance itself from collaborative paternalism, that is, benevolent acts aimed at

temporarily assisting the client to recover while disregarding the client's current wishes (unlike Pellegrino and Thomasma's (1988) model). There are numerous examples of when this collaborative paternalism is necessary, such as depressed clients who are threatening suicide, and clients under the influence of hallucinations or delusions who are threatening to do harm to themselves or others. Collaborative paternalism is limited, specific and only justifiable until the client can account for those activities or functions themselves.

Likewise, autonomy is not the aim of psychiatric practice; the aim is the beneficent one of furthering what is good for the client in terms of recovery from mental illness. Increasing client autonomy is a means to that end.

Summary

This chapter made a case for a collaborative virtue-based model as the best available model for the client-professional relationship in psychiatric services. The chapter critiqued rights-based and expert care models as being too focused on autonomy and paternalism respectively**.**

The collaborative virtue-based model would provide an optimisation of the virtues of clients and professionals and provide a vehicle for the expertise of both professionals and clients to be maximised.

In the next chapter I will have more to say about how the virtues necessary for client recovery can be developed through a recovery narrative.

CHAPTER 8
The Recovery Ethos Part III:
Constructing a Recovery narrative

This chapter will provide the third component of the recovery ethos, namely the need for clients to construct a recovery narrative of their illness experience. By recovery narrative I mean that clients are able to tell their story of a journey into mental illness and then of that journey towards mental health[1] in such a way that the experience of mental illness is seen to have a meaning for that person. For those who are currently receiving psychiatric services, this will mean the client possibly using the collaborative relationship with psychiatric professionals to explore the issues thrown up by the construction of a narrative through a virtue-based model, as discussed in the previous chapter.

This chapter will argue that constructing a recovery narrative is a critical component of recovery for clients who have been mentally ill by showing how important it is for people to tell their story in their own terms and thus make practical decisions about their own recovery.[2] This idea of constructing a recovery narrative is a crucial component of recovery since it affects the way clients view their own symptoms and functioning. A recovery narrative can be facilitated by the presence of virtues at critical points in the client's recovery journey. These crucial moments are called 'critical points'[3] since they are pivotal moments when clients can make decisions which will have serious implications for the rest of their recovery. In some sense, every decision or every moment is crucial in someone's recovery, but there seem to be moments of particular significance, where new pathways can be taken or new relationships established. The decisions clients make at these critical points (like other decisions they make) are influenced by the dispositions they have established in their life as well as their ability to rationally think through the options available to them. This combination of moral and intellectual virtues can be seen at its most crucial in these critical points.

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[1] Another way of phrasing this is to say 'recovery from' illness and 'recovery of' health.

[2] Parfit (1984) indicated the lessening of psychological connectedness between thoughts and memories as time progresses which raises the problem of the continuation of personal identity. However, I am assuming in this thesis that there is sufficient continuity of personal experience to talk about the same identity when discussing the recovery narrative, albeit one which changes.

[3] Empirical evidence does support this contention of key moments in someone's recovery. See footnote five below.

There are four sections in this chapter. Section One will provide a rationale for the way in which the construction of a recovery narrative can help people recover from mental illness. Section Two will explain the significance for recovery of narrative and narrative ethics. Section Three will show how the virtues connect to the notion of a recovery narrative through the 'critical points'. Finally, Section Four will show how the collaborative model can help clients take advantage of 'critical points' in constructing their recovery narrative.

Section One: Rationale for the Construction of a Recovery Narrative

In this section my aim is to explain why constructing a recovery narrative is vital for recovery from mental illness and then how that narrative helps clients to recover.

Constructing a recovery narrative is a vital component of recovery.[4] Unless a client develops an appropriate narrative they are unlikely to advance in their recovery. The relevant virtues can only be displayed where there is an appropriate narrative, which provides the client with a basis for reflection, a ground for hope, and a foundation for anticipating difficult moments.

Constructing a recovery narrative provides a necessary link between the virtues and the psychiatric community (to be discussed in the next chapter) in that recovery narratives are a means of promoting the virtues through moral education aiming at the goal the community has selected.

Constructing a recovery narrative is an important part of the illness experience for clients recovering from mental illness. This is not about discovering information which is already held somewhere but a more active and creative process of synthesising information, experiences, beliefs, feelings and thoughts into a coherent and meaningful account. The construction is always open-ended and provisional since the client never knows with certainty what will come next and, therefore, it is always in the process of development.

It might appear that the claim that constructing a recovery narrative will assist with recovery from mental illness is an empirical one. Although traditional

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[4] Gillett (1999) provides a broad philosophical justification for a discursive understanding of psychiatric care, which includes narrative.

empirical methods could provide evidence for the value of such an approach,[5] my focus in what follows is instead on how the recovery narrative forms a credible and coherent part of the recovery ethos.[6]

There are three main ways in which constructing a recovery narrative can help clients recover, based on the therapeutic nature of the storytelling process, the ability to find some meaning in the illness experience and the increased ability to make practical decisions helpful for their recovery. It is hard to say what exactly the psychological processes are which give rise to a changed view with regards their illness but the changing perspective seems to be connected with the *telling of the story*. As clients start to tell their own story, in their own terms, they take ownership of it and this helps them to see that the illness experience did not come out of nowhere but was part of their life.[7] Arthur Frank (1995) refers to this process as one of giving testimony to their illness experience. Frank believes that the testimony of suffering is the communal and individual moral duty of the ill person. In his discussion of Frank's understanding of testimony, Brody (1997) states that Frank wants us to rethink the way testimony works. Ordinarily we imagine a sick person thinks about their suffering, finds words to describe it and then communicates this to another, while the other, through some process of empathy, then imagines what it must be like to suffer in that way. But Frank sees this as too mediated an account, and argues instead that we fail to understand the power and importance of testimony unless we understand it in a more direct way. According to Brody's interpretation, we need to:

> See the story of the sick person as the suffering body itself giving the
> testimony of its suffering; and the listener to the story is necessarily

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[5] Such empirical research has occurred. Lapsley et al. (2002) interviewed forty participants on their recovery journey from mental illness. They found that stories fell into three broad themes: journeys into illness, journeys towards recovery; and onward journeys. While the focus of this research was more on what those recovery journeys look like qualitatively, rather than whether the telling of stories in itself aided recovery, there is a sense in which those who are on the recovery pathway become better able to make sense of their illness experience and so there is a chicken and egg element to this material.

[6] The most respected methodology in an empirical sense is a randomised-controlled trial. If one could assign clients into two groups, in one group the client and professional virtues through a collaborative relationship would be stressed, with the use of a strong narrative style. The other group would consist of treatment where the virtues in a collaborative relationship were not stressed and where the client's narrative was disregarded. Then we might have empirical evidence for this aspect of the recovery ethos. However, the ethical problems associated with this approach are obviously not acceptable. This problem will continue to attach to research connected to the virtues.

[7] Leibrich (1999) provides an example of the way in which individuals who have experienced mental illness, through telling their own story, take possession of that story and, through the ownership, some sense of meaningfulness. Another example is the equally compelling collection of client stories edited by Read and Reynolds (1996).

> present, not as a taker-in of information, but as herself a potentially
> suffering body that receives the testimony of suffering in a more direct
> body-to-body fashion (p.21).

This part of Frank's account of illness narratives is not altogether convincing. Even allowing for the possibility that sufferers of physical diseases such as cancer – as is the case with Frank who had cancer – experience testimony in the way described, it is hard to see the parallels with mental illness where the body *per se* is not involved and where we do not usually see the brain in any direct fashion, as psychosurgery has deservedly fallen from favour. Frank is on a mystical quest with regards to his understanding of testimony and the simpler view already mentioned, that it is about transmitting a story with great feeling to others, is a far more useful and meaningful account of testimony and hence of the essential motive behind the construction of the recovery narrative.

Constructing a recovery narrative helps clients find meaning in their illness experiences through their development of an 'explanatory model,' which is a client's attempt to answer the following types of questions: What is the cause of the illness? Why did it occur when it did? What are the implications of the illness? What is the source of improvements and exacerbations? What do I most fear about this illness? What do I expect from treatment? In other words, an explanatory model is the way a client accounts for the illness and the experiences associated with it. Developing an explanatory model is also directly related to the criteria for recovery itself, in that the client develops answers, from the client's perspective, to questions about symptoms and functioning. This explanatory model provides a partial picture of the mental illness the client is experiencing, since it is a subjective one, and as will be seen later on, can be combined with the explanatory model of psychiatric professionals.

While there have been many attempts to analyse the explanatory model of clients, the work of Kleinman (1988) has been one of the most influential. Kleinman distinguishes between three different aspects of an explanatory model, all associated with meaning. These are: the meaning of symptoms, the meaning derived from cultural circumstances, and the meanings derived from personal and social circumstances. All three of these are important in enabling clients to construct a recovery narrative from mental illness.

There are many symptoms associated with mental illness, and psychiatric professionals focus on identifying these symptoms in an objective way. Identifying

the subjective experiences of clients does, however, form part of the skill of recognising symptoms. Although psychiatric professionals use different explanatory models, the dominant one is the framework provided by the classification systems. Clients often have different sets of associations with their symptoms and do not see them simply as evidence of a mental disorder. Some clients find it helpful to use the same framework as psychiatric professionals but others find this too constricting. Part of the process of constructing a recovery narrative is for the client to start explaining what the symptoms mean to them in terms of their own explanatory model.

The meanings that people attach or associate with their illness experience can be influenced by that person's cultural circumstance. As Kleinman (1988) says, "it is not just that certain symptoms are given particular attention in certain cultural and historical settings, but that the meanings of all symptoms are dependent on local knowledge about the body and its pathologies" (p. 23). In order to construct a recovery narrative, some understanding by the client of their own cultural context is important since this will influence the meaning they associate with their experiences.

The final type of meaning – the personal and social – is one that has particular importance in chronic disorders. As Kleinman (1988) indicates, "Unlike cultural meanings of illness that carry significance *to* the sick person, this third, intimate type of meaning transfers vital significance from the person's life to the illness experience" (p. 30). For example, someone who has a mental illness such as depression may find that their experience of the illness is affected by their experiences of work and relationships. This personal experience of the meaning of mental illness is the area most difficult to contain within established explanatory models and hence the area most likely to suffer where the professional explanatory model is dominant.

The final way in which constructing a recovery narrative helps clients is to enable them to make practical decisions about their recovery. I will have more to say on this in a later section since this is the focus of the chapter, but essentially it links to the notion of 'critical points' in a client's recovery and the understanding of which virtues can be helpful.

Constructing a recovery narrative is a rational activity, but also necessarily an emotional journey. That emotional journey can best be understood through the use of narrative ethics.

Section Two: Clarifying 'Narrative' and 'Narrative Ethics'

The aim of this section is to clarify and justify the use of the terms 'narrative' and 'narrative ethics'. The term narrative is being used almost interchangeably with 'story' quite deliberately. Hunter (1992) says "in using the word 'narrative' somewhat interchangeably with 'story' I mean to designate a more or less coherent written, spoken or (by extension) enacted account of occurrences, whether historical or fictional" (p. 306). There are different ways of understanding the term 'narrative'. This thesis is associating narrative with the idea of story, but that still leaves some ambiguity. A fundamental distinction that needs to be made is between a person's life journey and the narrative of that life journey as a story. Narrative is the story that someone tells about something. In reality, these two often go together in that in practice, in order to learn about someone's life we need to hear stories about that life. In discussing recovery, the focus is upon the person's life journey, in the sense that we are interested in what really happens to the person. In order to find out about this life, we also need some narrative as a story, whether told by the clients themselves or by others. The focus in this thesis is on how the story the client tells themselves and others about their recovery can itself help with their progress. It is important that these two things are differentiated, even though they are so interwoven.

There are different types of stories that can provide insights into the client's life journey. These range from autobiography to memoir, biography to fiction.[8] In recovery from mental illness, clients will have their own story of the illness experience. If they write it down, which most do not, it will be a memoir or possibly an autobiography. If others write the story of their journey, it will probably be a biography, which raises the question of the status of clinical notes as the most common written record of a client's experiences. Clinical notes certainly tell a story; in some cases that story can be long and consist of several volumes of notes written by different 'authors,' most of whom do not see themselves as contributing to an overall story. Sometimes clients will add sections themselves in the first person, present tense but generally the clinical notes are written in a third person, past tense

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[8] Hardwig (1997) notes that there are different types of stories in narrative ethics but that the autobiography has become a dominant preoccupation, largely due to a societal emphasis upon autonomy. In broad terms I agree with this interpretation and with his solution, which is that we need to attend to many stories in understanding a particular client narrative. The collaborative model I have introduced in the last chapter is a model that attempts to value the possible multiple sources of stories.

style.[9] They are authoritative in that the health authority displays its logo on them and vouches for them in some official sense. These clinical notes have a general theme of treating and managing the client's mental disorder. Such an account purports to tell the truth of the client's disorder and attempts to provide an account of the client's life, which can only fail because it is focused upon mental disorder rather than mental illness. It cannot claim to be a full narrative because it is not a work of fiction (though sometimes entries can be fictitious) and nor is it a biography (even though like a biography it comments on another's experience of life). In clinical notes there may be multiple authors who moreover only comment on a particular component of a client's life, namely their mental disorder. It is, therefore, not surprising that many clients of psychiatric services complain that their experiences and their voice are not represented or captured by clinical notes. Such accounts tend to have a focus on disorder, so that a recovery narrative (in the broader sense) is not seen as part of the purpose of those notes. In most cases, once the disorder is under control, psychiatric services would discharge the client to other services.

Narrative ethics[10] in this thesis is simply the use of stories to make sense of practical decision-making in someone's life journey. As Nelson (1997) indicates, there has been in bioethics a turn away from impartialist accounts - since these accounts, as Williams (1981) has observed, remove much of what gives life meaning, such as love, commitment, friendship, etc. Stories are enormously important in the way we all make sense of the world. They are also particularly important in the way people frame their experiences and try to make sense of them. Historically, in psychiatric practice, the client's stories (in their terms) have been largely ignored. As Coles (1989) has shown, the client's story is a vital component of the psychiatric story but one ignored for a long time. Coles discovered, working as a psychiatrist, that it was only when he started to really listen to a client's story, and not purely in order to apply the correct diagnostic account, that he began to understand what psychiatric practice really meant.

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[9] Chambers (1997) points out that the problem for bioethical cases is the style in which cases are usually presented. In his view the 'bioethics case' has (he believes) become a genre in itself which has created expectations around its style. He believes that bioethical cases can be distinguished by their reportability. An event of some kind usually occurs with an ethical dimension, by their action or plot, by their tempo or length, and by their style of closure. He believes that there can be a tyranny of the genre in which only cases presented in a certain way will be considered 'real' bioethical cases, thus excluding many others, with clinical case notes perhaps being a case in point.

[10] Newton (1997) has a good general overview of the nature of narrative ethics.

Discussing recovery narratives in connection with ethics is moving towards the area of study known as narrative ethics. It will be useful to explore the meaning of this term. Murray (1997) understands narrative ethics as having four main meanings within bioethics: a) narrative as moral education; b) narrative as moral methodology; c) narrative as an appropriate form of moral discourse; and d) narrative in moral justification. In what follows I will discuss these four areas and indicate the connection with recovery from mental illness. My focus will be on the idea of narrative as moral education, for it is particularly relevant to my earlier discussion of the way in which psychiatric professionals can teach the virtues that clients need in order to recover from mental illness. The other three meanings of narrative ethics will feature to a lesser extent.

There is a long tradition of seeing narrative as a way of providing moral education. Fairy tales, as illustrated by Bettelheim (1988), and nursery rhymes are ways of communicating morality stories to children and, arguably, soap operas on television are ways of communicating moral themes to adults. The place of literature also indicates that moral ideas can be communicated through stories in ways that makes them digestible and understandable.[11] Narrative can therefore be seen, at the very least, as providing a way of educating professionals and clients about the way recovery from mental illness is possible. This is particularly true for issues connected with either relinquishing or assuming responsibility. For clients, this emphasis on moral education can take many forms, perhaps most strikingly through the use of personal testimony in which someone recounts their own personal experiences of recovery from mental illness. Personal testimony can be a very powerful form of communicating moral precepts and ideas. For example, the way in which someone manages to bounce back from successive relapses can be a 'morality tale' of sorts in which we hear of courage and the determination to recover. Testimony is always about someone's personal experiences, whether in the written or oral form of narrative. Narratives written about someone else's experiences of recovery can also be powerful. Such narratives, whether factual or fictional, can provide an insight into how it is possible to recover from mental illness. Paradoxically, reading or listening

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[11] Nussbaum (1990) has been a strong advocate of the moral value of literature.

to a story that lacks a positive resolution[12] can also be a morality tale that can help by indicating which choices and decisions will not assist in the recovery journey. Professionals have much to learn from narrative also. For professionals, this can simply be an example of how they can learn from the client's story. It can also be an example of the way professionals can learn from written narratives, such as clinical case notes, how to be less judgmental or more tolerant of the people they are trying to help. One of the most important ways in which moral education is important, however, is through the guidance and support of psychiatric professionals teaching clients the virtues they will need in order to recover. This teaching can take many forms, from explicit lecturing to being a role model of how certain virtues can help recovery and enable one to maintain health.

Narrative can be seen to be at the heart of the moral methodology used to explain ethical issues in healthcare. Even if practitioners are strongly wedded to principle-based care and rules, they invariably will place these in the context of the case study. The case study has a long history in psychiatric practice, and traditionally involves considerable gathering of data about the client's history in various forms, including for example the social, occupational, family and personal histories.[13] This involves a narrative thread even if the practitioner does not subscribe to a narrative case study tradition, since even the most rigorous psychopathological tradition of case study involves the practitioner telling the story of how the client came to have a mental disorder. If we were interested in the client's illness experience, then some narrative of how the client came to the present point would seem unavoidable. It might be said that the best case studies meld the psychopathology and narrative traditions together in a collaborative whole.

Philosophers and ethicists often use narrative in the form of hypothetical stories to support their views[14]. As Murray (1997) indicates, hypotheticals have had a long tradition in philosophical writing, and are often used as a way of showing the plausibility or implausibility of some assertion in ethics. It seems to be the case that

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[12] An example of a narrative lacking positive resolution in the form of a diary that could be used paradoxically (i.e. what not to do for someone intent on recovery from mental illness) could be Strindberg's famous writings(1979).

[13] The American Psychiatric Association (1994b) provides one of the best known case study based publications in psychiatric practice based on case studies, and illustrates the way even very psychopathologically orientated publications still use a strong narrative thread.

[14] Perhaps one of the most celebrated examples of this in ethics is MacIntyre's (1981) opening chapter of *After Virtue* where he paints a disturbing picture using storytelling techniques.

narrative helps to advance arguments, not in a direct sense but by pushing our intuitions by indicating the extreme implications of particular points. In working with recovery from mental illness, the need often arises, for example when discussing particular issues related to the future of a client's care, to resort to hypothetical situations and hence to some form of narrative. In this context, narrative refers to more descriptive and detailed situations than basic statements such as 'What if you didn't have your wife to take care of you next year?'

Narrative sometimes assists in moral justification. The way in which we come to know or believe that our moral judgements are accurate is a complex process. Narrative can assist in moral justification through its connection to dominant narratives that exist within any particular society. Dominant narratives are stories that are believed by most people within that society and certainly by the dominant members of that society. All societies have stories about, for example, the role of men or women. These dominant narratives can provide one means (though possibly not the best means) of understanding complex issues. Also, and perhaps of greater relevance for psychiatric services, there is the way that narrative can provide a justification for particular interventions or decisions based on the stage that a client has reached in their recovery[15]. For example, a client in crisis would justify more paternalistic interventions than a client actively recovering.

The following section will link the notion of narrative to critical points in a client's life and indicate that it is the acquisition of key virtues at these moments which can aid or hinder their recovery. Developing a recovery narrative can help with acquiring these virtues since these critical points occur at key moments along the client's recovery pathway.

Section Three: The Virtues and Decision-Making at Critical Points

This section aims to show how clients can make practical decisions in their lives during 'critical points' of their recovery by acquiring particular virtues. Clients acquire these virtues in many ways, pre-eminently through moral education. The stories clients tell themselves about these critical points are a significant way of developing these virtues.

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[15] One way of understanding this notion, as MacIntyre (1981) has indicated, is related to the idea of 'narrative unity' by which he means that each person has a story that spans that person's life and holds them accountable for the actions and experiences that compose a narratable life.

Both client and professional virtues have an important role to play in ensuring that the experience a client has of mental illness is recovery focused.[16] Critical points[17] are the crucial decision-making crossroads in mental illness experience. My claims about these critical points are neither empirical nor conceptual and are offered simply as suggestions about what might possibly be happening.

The virtues discussed earlier in this thesis are needed at all points in a client's recovery. Of course, in many cases the client will not have fully acquired some or all of these virtues, and will still have habits that make acquiring or exercising the virtues difficult. Nevertheless, I would maintain that at key moments – critical points – particular virtues need to be present if the client is to move forward in their recovery. If the client does not have that particular virtue at that point, then he or she will need to wait until they acquire that virtue before making progress.

The following discussion of critical points in connection to the virtues needs to be seen as a broad outline of a story that the client can come to tell themselves about their experiences. As I have already indicated, a recovery narrative involves clients telling the story of their illness in their own way, in ways which are meaningful to them. It will be for the client to provide the detail to these stories of critical points and thus to own them. Clients who start to tell themselves stories about their experiences in the way that follows are more likely to take advantage of the critical points and thus assist with their recovery journey.

The virtue of hopefulness is a pivotal virtue early in someone's illness experience.If, in the first few days of their illness experience, the client does not have hope - at least in the attitudinal sense- that matters will improve, then it is possible that their recovery will be set back. The hopeful person can view their current state as one that can move to a better state. While this virtue will be important at other points in their illness as well, in the first few hours and days of their illness experience it is particularly important. It may well be that initially the client is too critically unwell to have any sense of emotional feeling, so the critical point is that first realisation of self-awareness that they are in hospital or receiving assistance.

In addition to hopefulness in the first few hours and days of their illness experience, clients need to show trust and collaboration from the earliest moments of

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[16] Recovery focused simply means a focus on an improvement in symptoms and functioning.

their experience. Without trust, a vital critical point will have been lost, possibly resulting in a poor relationship with psychiatric professionals being created. Once again, a client who is very unwell may not be psychologically able to make sense of their emotions, so the critical point will be the first moment when the client has a sense of being able to trust or not trust psychiatric professionals, which will form the basis of the collaborative relationship.

Self awareness[18] has many shades and can be seen to lie on a continuum. At one end there is a lack of self awareness when people are unconscious or asleep (though there is a continuum even within sleep). There is a level of partial self awareness that covers a wide variety of mental states and includes people who are mentally ill, from those with little self awareness to those with reasonable levels of awareness. There is a level of more normal self awareness, which includes most people most of the time. Finally, at the other end of the continuum, there is a level of extraordinary self-awareness. It is important to realise that self-awareness has these various shades. The virtue of self-awareness is something that can be worked on and developed to a certain extent. At the lower levels, moving from no awareness to partial awareness, pharmacotherapy, (or at least biophysical interventions), is probably a major factor in increasing self awareness, but in later parts of that continuum further developments will require more self directed activity such as meditation. As a consequence, there are several critical points when it comes to the virtue of self-awareness. If someone is in a crisis state, such as a critical psychotic state, they will probably have very limited self awareness. At this moment, the critical point is not specifically about self awareness but about trust and collaboration. If the client can trust the professional and collaborate with them,[19] then it is likely their critical symptoms will decline and a higher degree of self awareness will become evident. In moving from partial to substantive self awareness in their life, the client can make choices that will either contribute to or undermine their attempts to increase their self-awareness. For example, the client who decides to attend a self-help group will probably gain greater insights into their own character and interaction with others than someone who chooses not to.

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[17] In Lapsley et al., (2002) it was found that clients in their research referred to the idea of turning points as representing a moment when they make a decision that has important implications for their recovery.

[18] Insight, which is an important test in psychiatric interviewing, can be seen as variety of self awareness.

Responsibility as a virtue is relevant to a number of critical points. Firstly there is the moment, perhaps paradoxically, when the client realises they cannot assume responsibility for their life or some aspect of their life. This will clearly be dependent on the level of self-awareness obtained. A second critical point in terms of responsibility is that moment when, perhaps for the first time in their illness experience, the client takes ownership of some aspect of their care or treatment. It may initially be a minor or even insignificant matter, but the crucial thing is the taking ownership of it and hence responsibility for it. In order to take responsibility, the virtue of courage is needed since it is difficult (sometimes beyond belief) to take what is – from the clients' perspective – a step in the dark. Courage, however, is crucially important in large-scale steps or changes; for example, moving from inpatient facilities to community services; from seeing psychiatric professionals frequently to less frequently.

The virtue of perseverance is important for the whole of someone's illness experience but there are at least two critical points when perseverance is pivotal and where an illness experience can lose its recovery focus. The first of these is during that period of the illness experience when the acute symptoms have gone, when some of the previous pre-morbid level of self-awareness has returned and there is a need for the client to stick with a rehabilitation programme of some kind. For example, reacquiring life skills and vocational skills can take a long time and without perseverance it is likely the client will give up at the first sign of problems or difficulty. A second critical point is later in their illness experience, when the client has to stick with their wellness maintenance programme. A wellness maintenance programme is essentially a list of things the person can do to keep well; this might include getting a good night's sleep, abstaining from alcohol, avoiding stressful situations, and continuing to take their prescribed medications.

The virtue of honesty is particularly important in the partnership phase of rehabilitation where the client's explanatory model and the professional's explanatory model are coming together and some negotiation starts to occur for a mutually satisfactory explanatory model. At this point, client honesty is a recognition of what they have achieved, and what they are (and are not) capable of achieving for themselves. Another critical point in terms of this virtue of honesty occurs in the later

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[19] Some mental states, such as paranoia, make this difficult.

stages of their illness experience when a client is assessing whether they can be discharged from psychiatric services. While this decision might (and usually is) made by psychiatric professionals, the client has an important role in honestly determining – using practical wisdom – whether they are able to take care of themselves. The risks of continuing to receive care from psychiatric services unnecessarily are in many respects as significant as those involved in discharge when further psychiatric services are needed.

The virtue of self-discipline has at least three critical points. The first of these is upon being admitted into psychiatric services and involves the client following the treatment plan or crisis plan established with psychiatric professionals. The second occurs when the client is discharged from inpatient to community services (or in the case of clients receiving community services alone, discharged from the service). Upon being discharged the client will have a sudden sense of freedom and without self-discipline over their budget, lifestyle and treatment plan it is likely that their illness experience will not be recovery focused. The third critical point occurs when a wellness maintenance regime has been established following their discharge, and when self-discipline is needed to continue with the programme.

Clients can learn to tell a story of their illness experience and the critical points that can feed into their construction of a recovery narrative. The value of this is that if they fail to exercise the virtue needed to take advantage of a recovery point on this occasion in their life journey, next time (perhaps after a relapse) the narrative will help them to know how best to deal with a possible future relapse in the sense of making better decisions.

Section Four: Client Narrative about Professional Relationships

The aim of this section is to show that in the same way that clients can tell themselves stories about their illness experience and the importance of critical points in their recovery, they can also tell themselves stories about their relationship with psychiatric professionals. This can assist their recovery.

Chapter 6 indicated the key features of the collaborative virtue-based model between clients and psychiatric professionals. The collaborative relationship (in the form of the model proposed) is a crucial factor in ensuring that clients are able to take full advantage of the critical points when they arise in their experience of mental illness. However, it is more likely that clients will have a collaborative relationship if

they have learnt to tell themselves and others stories about their experiences with psychiatric professionals that are collaborative.

Clients tell themselves and others many stories about their experiences with psychiatric professionals. However, there are two types of story which are particularly unhelpful for recovery. The first type is about needing to always make decisions for themselves, or to be independent, which makes it difficult to collaborate with professionals. The second type of story is about always needing to follow a professional's advice and not making decisions for themselves, which is also unhelpful in terms of developing a collaborative relationship.

There are various ways in which the collaborative relationship with professionals can help with clients utilising the critical points. There are three main ways: firstly, clients can learn what the critical points are; secondly, they can learn how to recognise the critical points; and finally, they learn who can help them get over the various critical points.

Clients learn how to tell themselves 'collaborative' stories with professionals through moral education, since clients primarily learn through their own personal experience or through the teaching of professionals. One way of learning through personal experience is by developing a 'collaborative story' of their experiences with psychiatric professionals. A collaborative story is simply a story – part of a recovery narrative - of how clients and professionals can work together to achieve a mutual goal.

In the following discussion I provide a broad outline of the kind of story a client could tell themselves about how a collaborative relationship with psychiatric professionals could work in utilising the critical points. Once again, it is for the client to provide the detail to this story for themselves.

If they have a collaborative relationship, the critical points can be utilised more easily by the professional and client. In the case of hopefulness, a virtue seen as quite foundational early in someone's admission into psychiatric services, collaboration can be crucial. The expertise of the professional can help provide a realistic assessment of the severity of the situation while the client's expertise can show how, as an individual, they might overcome their present problems. All of these provide the basis necessary if the client is to be hopeful about their situation.

In some respects, collaboration is the perfect antidote to suspicion between clients and professionals and hence contributes towards creating a trusting

relationship, particularly during the early critical point when clients have just entered the service. If the professional and client are able to collaborate, even over small matters, there is more likelihood that they will come to trust each other.

As was shown, the client's virtue of self awareness affects a number of potential critical points corresponding to the various phases in the self awareness continuum. In the early critical point when there is partial self awareness for the client, a collaborative relationship with a professional can ensure a more tailored individual dose of medication, for example. Later, critical points can be assisted through appropriate and tailored educational or psychological interventions. Collaboration, which is needed from the start, has a vital role in the rehabilitation phase, or partnership phase, of recovery.

As was shown, the virtue of perseverance has at least two critical points and the collaborative relationship can be helpful in realising both. The first occurs in rehabilitation and is marked by a concern with both illness and health. Rehabilitation is often seen as the crossover period between illness and health and the related client-professional explanatory models. The critical point in this phase of the illness experience is the ability of the client and professional to pool their expertise and work together for the client's good. The client's illness experiences will probably not be recovery focused if they are unable to appreciate the expertise the professional can provide at this point.

The collaborative relationship can assist clients with self discipline through support and encouragement, which will mean clients can take advantage of all three of the critical points connected to self discipline.

Without collaboration occurring in the way described, the possibility of clients assuming appropriate levels of responsibility for their own healthcare becomes very difficult. For professionals to relinquish responsibility for particular activities, they need to know and understand the client they are working with and in order for that to happen there needs to be collaboration.

The client and the professional working together can influence the recovery narrative the client is starting to develop about their experiences. The idea that collaboration between client and professional changes in the course of the client's illness experience is vital. For their decision-making to be recovery focused, the narrative that the client is constructing also needs to include this changing collaborative relationship.

Summary

This chapter has detailed the third part of the recovery ethos, that of developing a recovery narrative for clients recovering from mental illness. This aspect of the recovery ethos needs to be seen as complementing the virtues already discussed in Chapter 6.

Clients can begin to construct their own recovery narrative and this is a vital component of recovery from mental illness. Constructing a recovery narrative is essentially about learning to tell one's own story in one's own way. An important distinction was drawn between a client's life journey and the narrative about that life, indicating that the focus was on the client's life journey, since a narrative can be potentially false. The interest is not in the narrative in the final instance, but in the life itself, more specifically, in making that life journey go better.

It was indicated that there are critical points, which are fundamental moments when recovery could be assisted or impeded, and that progress during these moments depends upon particular virtues. It was also shown how the collaborative relationship between professionals and clients could help utilise those critical points. The kind of narrative a client constructed of their experiences impacted on their relationship with professionals and accordingly their ability to take advantage of the critical points.

The recovery ethos exists at several levels. For the individual client there is the recovery narrative and virtues, while in terms of their relationship with professionals, there is the collaborative model. There is also the level of the psychiatric community. The next chapter will show how the psychiatric community provides an essential basis to the virtues and narrative already discussed, in terms of developing a recovery ethos.

CHAPTER 9
The Recovery Ethos Part IV:
The Psychiatric Community

This chapter will present the final component of the recovery ethos. The virtues, the client-professional collaborative model and the client recovery narrative are vital components of the recovery ethos considered from the perspective of the client and the psychiatric professionals who are working with the client. This chapter will make the case that the recovery ethos needs to be based in the psychiatric community as a whole.

The purpose of this chapter is to show how psychiatric services need to share the recovery ethos with other mental health services to form a psychiatric community, in the sense of a group with shared values and goals. Such a psychiatric community does not currently exist because of the justice/autonomy split between psychiatric and other mental health services (excepting primary services). The chapter will also show that such a psychiatric community is vital to fostering recovery in a pluralistic way.

'Psychiatric community' is a term that needs to be explained. The thesis will use an Aristotelian understanding of the notion of community. A community, in the Aristotelian sense, is a group of people who share a common goal or *telos*. The character traits that are considered to be virtues depend on this goal, and narratives are a means of promoting these virtues (i.e. through moral education).

This thesis has been concerned with psychiatric services, which has meant those services provided in New Zealand through publicly funded psychiatric services to those with serious mental disorder. However, as mentioned previously, there are also other mental health services in New Zealand, provided by non-governmental organisations (NGO), primary providers and private providers. There have been differences in the application of the procedural ethos between these various services. This difference is particularly marked in the way that psychiatric services are geared towards justice as the dominant principle and non-governmental and private services are geared towards autonomy. This split, in itself, has helped to undermine the possibility of a psychiatric community. However, in this thesis, reference to 'psychiatric community' includes all the current psychiatric and other mental health services: that is psychiatric services, primary services, NGOs and private care and all the professionals and clients associated with them with the shared *telos* already

mentioned. It is this expanded notion of psychiatric community that I have in mind, not a community simply based around current publicly funded psychiatric services.

This chapter, at first glance, may appear to introduce a focus upon political philosophy at odds with the direction of the rest of the thesis. However, this would be a serious misreading of the chapter. While it certainly casts an eye over some political terrain, it does so in order to show how the psychiatric community is necessary if we want a recovery ethos.

Section One will show that, currently, a form of liberalism is dominant as the service approach within psychiatric and other mental health services, which has had dire consequences for the whole notion that there can be a psychiatric community. The section will provide this analysis through an historical overview.

Section Two will provide an analysis of how the development of a psychiatric community needs a common *telos.*

Section Three will show that liberal communitarianism is the best approach for developing that common *telos.*

Section four will show how a psychiatric community can provide the basis for the recovery ethos through a pluralistic approach to fostering recovery.

Section One: Dominance of Liberalism

The aim of this section is to show that presently liberalism is dominant within psychiatric and other mental health services. The procedural ethos, which is the current *de facto* philosophy of psychiatric and other mental health services, is based on liberalism. An historical analysis will be provided showing how liberalism became dominant within those services replacing earlier notions of 'community'.

New Zealand, like many other western countries, could be described as a liberal democracy in that it has a respect for individual rights, for the rule of law, for diversity in conceptions of the good life, and a system of democratic institutions. Currently there are various forms of liberal democracy, from an individualistic liberal democracy such as the United States, to more socially orientated countries such as Japan. New Zealand is probably tending towards the individualistic end of that spectrum.[1]

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[1] Fukuyama (1992) makes the case that liberal democracy is spreading throughout the world and that it represents a final political form and hence his term 'end of history'. However, it is not necessary to accept his conclusion on the end of history to accept that liberal democracy is on the rise and that it has

It is not part of my focus in this thesis to explore the political form of New Zealand's liberal democracy. It is, however, my focus to show that the liberal assumptions that govern our political life have also come to dominate psychiatric services. These psychiatric services are comprised of psychiatric professionals and their clients and the various service infrastructures that make such services possible.

As discussed in Chapter 1, the current procedural ethos has been with us for only a relatively brief period of time. The clinical-expert ethos, the utilitarian ethos and the superstitious ethos preceded it and formed and shaped the psychiatric and other mental health services in ways that partly made those services unique.

It can be argued that psychiatric services, as we now understand them, had their origin in the asylums and were characterised by the utilitarian ethos which was concerned with the consequences of treating large numbers of people for the greater good of society[2]. The early utilitarian ethos contributed a great deal to psychiatric services, something which is still present: namely a strong focus on consequences, particularly the need to weigh up the risks and benefits of any proposed action. The psychiatric service during the asylum period was characterised by something of a divide between clients and those caring for them, which probably contributed to the dependency and paternalism that the asylum system engendered.

As the utilitarian ethos merged into the clinical-expert ethos, many aspects of psychiatric services that are still with us came to be established. A stronger sense of being a separate service became evident in the late Victorian and early Edwardian periods. This was manifested in separate activities; laws, procedures and activities occurring in the asylum which would not be permitted or tolerated outside. For example, in late Victorian asylums it became quite accepted for clients to work in the fields and factories attached to the asylum for no money or at least only a token payment[3]. The justification was that this was therapeutic. While it might have been therapeutic, it should be remembered that clothing and other items sold by the hospitals did make money and this money was ploughed back into the asylum. From our perspective today this appears an illiberal practice that does not seem to respect the work practice of individuals, though such practices continue to have a small role

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given considerable scope for human improvement to those societies who have embraced it, most importantly through the relative peaceful co-existance of liberal democracies.

[2] See Shorter (1997) for an explanation of the way in which increasing numbers of clients were housed in the asylums during the Victorian period.

[3] See Williams (1987) for a New Zealand perspective, based on a history of Porirua hospital.

within psychiatric services. A different ethos was at work here, one still informed by the utilitarian ethos and the implicit understanding of the dependency of clients upon the asylum system.

Psychiatric services under the clinical-expert ethos became a paternalistic service, where individuals deferred to the authority of the psychiatrist and superintendent. This paternalism was perhaps more marked than in any other service. The range and depth of paternalism practised in psychiatric services was all encompassing. It covered what clients would do with their time, what they would eat, whom they would associate with and even when they would go to bed. It was a total institution.[4]

During the asylum period, psychiatric services created a particular type of 'community'. It was a 'community' that had a strong bias towards paternalism and to the value placed on the perspective of the expert and correspondingly had little respect for the stories told by clients of their illness experience. While it has become commonplace to reject the approach of this period, it is impossible to fully understand the kind of virtues needed to recover from mental illness without having some appreciation of the history of this 'community'. Virtues such as compassion, trust, sympathy, technical expertise and the way psychiatric services accepted considerable responsibility for clients, were all-important virtues and were refined during this period. Likewise, clients often showed and were encouraged to show trust in professionals, along with a certain measure of self discipline and perseverance to apply the necessary treatments.

All across the western world, the psychiatric asylums started to close from the nineteen sixties onwards. There has been much debate on the reasons for this development. Whatever the combination of economic or therapeutic reasons that converged to make closure necessary, there can be little doubt that the culture of the psychiatric asylums had become untherapeutic (because of the level of paternalism) towards the end. Closing the asylums became not just an opportunity to start again for psychiatric services, but a chance to get rid of the kind of 'community' the asylums had created. As Barham (1992) wrote:

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[4] This sense of the psychiatric community as a total institution has perhaps been best captured by Goffman (1961) in which he indicated what was involved in an asylum being a total institution. He discussed the institutionalisation that was caused by this socialisation process and how institutionalisation could look surprisingly like the effects of mental disorder.

the concept of community care did not seem to require much specification simply because the character of the ex-mental patient in the community remained to a large degree unspecified. The distinctive character of the mental patient of a previous era could, it was believed, now be erased from the script of social life and replaced by a less remarkable or distinguishable persona (p. 12).

Of course, the reality was that communities are not determined by bricks and mortar but by the narratives and character of people that underpin them. Closing the asylums ended the 'community' that the asylums had created and in its place came various services but no overall 'community'. Since there was an attempt to erase evidence of that previous 'community' at a formal level, it meant that informally new services developed to take its place, for example, self help movements of one kind or another, community centres, day centres and the like[5].

In attempting to eradicate the asylum another conception of 'community' was emphasised. This was the 'community' that ex-mental patients (during the asylum period the term patient was preferred) needed to join. It was the 'community' beyond or outside of the asylum walls. The reality was that this 'community' often did not see itself as a 'community' and was less than welcoming to those who had a history of mental illness. Without a real 'community' to fall back on, many ex-patients found readjustment difficult. While it was difficult for patients, it was also difficult for psychiatric professionals, who had also lost their asylum-based 'community'. Or, at least, they were encouraged to let that previous sense of 'community' go. In the process of trying to eradicate that previous asylum-based 'community', the newer procedural ethos started to arise as a way of achieving consensus.

The procedural ethos (as discussed in Chapters 4 and 5) has become the underlying philosophy of psychiatric services due to the need to replace the clinical-expert ethos. This period of replacing the clinical-expert ethos with the procedural ethos coincided with an increasing focus on liberal rights in society and the realisation that there was nothing to replace the expert with. This dilemma was more marked in psychiatric services than elsewhere because not only was there disagreement about philosophical questions in psychiatric practice but also disagreement about

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[5] These centres are now all considered to be non governmental organisations.

methodological and causative questions. The level of disagreement, it was thought, could only be resolved by an appeal to liberal principles as a way of dealing with diversity. However, remnants of the previous asylum-based community and the clinical-expert ethos remained, so the psychiatric services that appeared with the procedural ethos were a strange blending of liberalism and paternalism.

This blending of liberalism and paternalism is a strange combination in psychiatric services. It is a unique combination in that individual rights, personal freedoms and autonomy are respected within the context of a paternalistic framework where individual rights can be removed, that is, autonomy can be overridden by a particular understanding of justice[6].That understanding of justice is not the pure liberal one where someone's rights are removed and their liberty curtailed because they are imposing on others, but the more serious case where liberty can be removed or curtailed because someone might hurt others due to their mental disorder. This psychiatric approach to justice does exist, it is true, within a liberal society where laws exist permitting psychiatric services to act in the way they do. Those laws and the sort of psychiatric practice we have now, have been formed partly by the historical legacy of the psychiatric past.

The procedural ethos was introduced partly to resolve the problem of diversity of views but also to deal a death blow to the clinical-expert ethos. It could be argued that the clinical-expert ethos did involve some untherapeutic ingredients that needed to change. Unfortunately, in trying to change the culture of psychiatric services and make them less paternalistic, damage was done to the notion of a community. An asylum-based community which had developed over hundreds of years and which had developed some useful, creative and specific ways of dealing with psychiatric problems was, in a short space of time, dismantled[7]. As this community was in the process of being dismantled it was stigmatised as unhealthy. It was thought that it was no longer a good idea to have people with psychiatric problems being together. Individuals with psychiatric problems, it was commonly believed, should be living in *the* community not in some separate 'community'. The wholesale dismantling of the asylum-based community, while necessary in itself, has

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[6] While beneficence also provides a justification for overriding client autonomy under some circumstances, justice remains the dominant principle in psychiatric services. Where beneficence and justice come into conflict, justice will be the dominant principle.

done damage to any potential psychiatric community. While there is much about that earlier asylum community that we may wish to abandon, the dismantling during deinstitutionalisation was too sudden and complete. The asylum based community did have a *telos* based on clinical expertise which ensured that the community had a common purpose. As the asylum based community was dismantled, a fragmentation occurred in the numbers of psychiatric and other mental health services and with it any common purpose or *telos.*

As we have already seen, with the procedural ethos in psychiatric services the principle of justice has come into sharp focus, whereas other mental health services (excluding primary services) have become focused on the principle of autonomy. These services have, consequently, come to see themselves as being in competition or at least as non-complementary.

The appeal to recovery as the philosophy of psychiatric and other mental health services it was hoped would provide a common purpose. However, as I have indicated earlier, recovery itself has been proceduralised and has not succeeded in becoming an ethos since different forms of the procedural ethos have made agreeing a common purpose impossible.

Section Two: Development of a Psychiatric Community

If psychiatric and other mental health services are to become a psychiatric community, there needs to be a common purpose or goal. That common purpose was there in earlier periods, during the clinical-expert ethos for example, but in ways which were untherapeutic.

An ethos, though hard to pin down, is an important part of any community. Currently the procedural ethos is the dominant philosophy in psychiatric services. In terms of the notion of developing a psychiatric community, this ethos has unfortunately been very damaging. The procedural ethos has helped to individualise care which, while arguably a good thing in itself, when taken to extremes has tended to undermine the possibility of a psychiatric community.

To develop, the psychiatric community therefore needs a philosophy that recognises the importance of this tradition. The recovery ethos is such a philosophy,

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[7] As the asylums were dismantled they were replaced by psychiatric services and many other mental health services, which included non- governmental organisations, private services and primary services.

which recognises character and narrative but which is open to the need to respect the traditions of the past. Respecting the traditions of the past does not mean uncritical acceptance of them. There will be elements from the past that we need to abandon; there will be new developments we need to adopt. Such an approach is gradual and incremental rather than sudden and absolute. The dismantling of the psychiatric asylums during the deinstitutionalisation period was, in many respects, a sudden and absolute attempt to abandon the traditions of the psychiatric community as it had developed up to that point. Such a dismantling shows little respect for the traditions of the past in psychiatric practice. An attitude towards respecting traditions is perhaps best captured by MacIntyre (1981) who says:

> … a living tradition then is an historically extended, socially embodied argument, and an argument precisely in part about the goods which constitute that tradition. Within a tradition the pursuit of goods extends through generations, sometimes through many generations. Hence the individuals search for his or her good is generally and characteristically conducted within a context defined by those traditions of which the individual is a part, and this is true both of those goods which are internal to practices and the goods of a single life (p 207).

Psychiatric and other mental health services with their own distinct traditions, values, history and ways of developing character form an essential component of the recovery ethos.

However, one of the main purposes of such services is to agree on the *telos* of clients and professionals being there, the purpose and goal they are aiming at. This *telos* needs to be explicit and connect to the community in clear and (preferably) participatory means. As indicated, that *telos* was present during the clinical-expert ethos. Unfortunately, the liberal agenda that has become dominant in healthcare generally and specifically within psychiatric services, has removed the *telos* and replaced it with procedures that are meant to be neutral and impartial. It is not part of my purpose to critique liberalism per se, though there have been attempts to show that liberalism assumes notions of the good. However, what is clear is that the variety of liberalism and paternalism underpinning the procedural ethos within psychiatric and other mental health services does make explicit assumptions about justice and autonomy which provides a confusing and contradictory sense of the goods which are being pursued in those services.

In the remainder of this section an indication of what the *telos* of the psychiatric community should be will be given. This *telos*, while based on the goods to be pursued, will also provide a solution to the problem of focusing on the principles of justice and autonomy. Psychiatric services, like much of healthcare, are motivated by the need to do things that are *for the client's good*. This is fundamentally the purpose of psychiatric and of other mental health services. Therefore, the *telos* of psychiatric and other mental health services can be seen as acting for the good of the client.

Perhaps one of the most widely respected attempts to understand the client's good is that of Pellegrino and Thomasma (1988). Drawing upon an Aristotelian understanding of good in relation to the virtues, and rejecting autonomy and paternalistic-based approaches to client good, they see client good as having four strands. As they say: "Inherent in the physician's offer to help is a promise to use her knowledge and skill for the patient's good" (p. 76). They see the client's good as having four strands: the client's concept of ultimate good; the good of the client to choose; the particular good of the client; and the biomedical good. Firstly, the client's concept of ultimate good; by this they mean "the concept we hold of the ultimate good is the reference standard for all decisions, including clinical decisions" (p.77). This ultimate good, or good of last resort, underlies all other decisions. It is often the good that is hardest to articulate. Ultimate good refers to bedrock values that people hold, such values are not reducible to a more fundamental value. It is often in connection with ultimate goods that conflicts arise in clinical practice (or life generally).

Secondly, the good of the client to choose, by which they mean the good of:
[the] patient as a human person, with freedom to make his or her decisions…[so] to place medical good or the quality of life ahead of freedom to choose is to rob the patient of their humanity …[However,] the once-competent person who at the time of the decision is comatose, psychotic, or otherwise unable to reason and choose does not lose claim as a human being to have his interests respected (Pellegrino and Thomasma 1988, p. 88).

In some cases, surrogate decision-makers or proxy decision-makers will be needed to make decisions for the client while they are incompetent. These surrogate choices must be as near as possible to what the clients would have made for themselves. If no

surrogates are available, then health professionals will need to make the decisions, hopefully basing their decisions on the life plan or perceived life plan of the client.

The third strand of client good is the particular good of the client. This involves the client's own perception of the particular good of the moment. The difference "between this and the previous step, then, is the difference between laying down a life plan or system of values and making an individual choice or preference about treatment" (p.89).

Fourthly, there is biomedical good. As Pellegrino and Thomasma (1988) define it, this should be seen as the basis of health professionals making decisions for the best interests of clients based on their technical competency.

The four strands of client good are in ranked order with ultimate good being the highest good and biomedical the least. According to Pellegrino and Thomasma, this provides a meta-ethical scheme for ranking goods which can assist with clinical decision-making[8].

Psychiatric and other mental health services are fundamentally about the client's good and the client's good is achieved by helping the client recover from mental illness. Pellegrino and Thomasma's ranking of client goods is helpful. While there are problems with their ranking, it is not part of my purpose here to critique this.

The *telos* for developing a psychiatric community can, therefore, be seen as the client's good, with some possible ranking of conceptions of client good. In other words, the *telos* of the psychiatric community is the good of the client in connection with recovery from mental illness.

However, while particular services may agree on ways of helping clients recover from mental illness using some ranking of client goods, if we are to have a psychiatric community committed to a recovery ethos, we need a community which actually sees itself as a community. I want to turn now to how the various disparate services in the psychiatric and other mental health sector can come to see themselves as a psychiatric community.

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[8] Additional to this, Pellegrino and Thomasma (1988, pp. 84-86) provide a way of resolving disputes: clear directives from the client should come first, followed by negotiated values of the client, proxy judgments, hospital ethics committees and the legal system.

Section Three: Liberal Communitarianism

The aim of this section is to show how liberal communitarianism is the best way of developing a common *telos* for psychiatric and other mental health services and of helping these services to see themselves as a psychiatric community.   What follows can, therefore, be seen as an ideal in many respects, though in the case of New Zealand it is an ideal quite readily realisable since some of these organisational structures are already in place. In order to follow this aim, a broad political vision of liberal communitarianism, contrasted with liberalism will be presented.

Liberal   communitarianism is not a new idea; Aristotle and Rousseau have certainly advocated such a perspective amongst classic philosophers. In modern times, there have been many advocates of such an approach.[9] Modern liberal communitarians have developed their ideas in response to the perceived dominance of liberalism. Classical Liberalism is founded on the ideas of John Locke and, to some extent, the work of Thomas Hobbes. Both Locke and Hobbes had a starting point in a state of nature in which the first law was derived from the most fundamental of all passions, that for self-preservation. This state of nature was, however, unpleasant in many respects and hence people chose to leave it and establish civil society. In doing so, they forfeited their absolute right to executive power and transferred this onto the government. The government's purpose was limited to protecting property, life and liberty (the framers of the American constitution certainly subscribed to these ideas) and government would put aside the various conceptions of human good, since this led to disagreements and hostility – particularly due to religious rivalry.

Liberal communitarianism is fundamentally an approach which, like liberalism, assumes that individuals are autonomous and that there is a diversity of values in society. Unlike liberalism, however, a liberal communitarian also believes that the community within which an individual exists also has a role in forming the individual in the first place. Also the community needs some agreement between those individuals on the types of goods being pursued. This agreement is achieved through toleration, discussion and persuasion.

Until quite recently psychiatric services were effectively 'the psychiatric community' in that there was a common *telos* during the asylum period when the

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[9] Michael Sander, Alasdair MacIntyre, Charles Talyor, Robert Bellah, William Sullivan, Benjamin Barber and William Galston are some of the best known advocates. Though quite a disparate group,

clinical-expert ethos was dominant. Today there is no psychiatric community since there is no agreed *telos*. As already indicated, during the clinical-expert ethos, when the psychiatric community was synonymous with psychiatric services, it was easier to have a common purpose. Today there is no longer a common purpose for psychiatric and other mental health services. This has generated significant disagreements, which the procedural ethos has attempted to resolve, unsuccessfully in my view, due to differences in the principles underlying the procedural ethos. Psychiatric and other mental health services have become fragmented following the recent closure of the asylums and with it the loss of any agreed common purpose. This deinstitutionalisation of the asylums and the so-called 'community care movement' which followed has seen a worsening split between psychiatric services and other mental health services for those with serious mental illness. In some services, for example, there is a focus on treatment of mental disorder, whereas others focus on the social integration of clients. In some services, symptom reduction is seen as the crucial criterion for determining recovery, in others, functioning is.

Liberal communitarianism could help with the development of a psychiatric community by identifying a common purpose and clarifying the client's good in a way that is consistent and intelligible both within the community and to the wider society.

If psychiatric and other mental health services are to become a community with a shared purpose, there needs to be some basic structural changes in the way services are delivered. As Emmanuel (1991) has indicated, a liberal communitarian approach can be applied successfully to healthcare. As services are currently delivered, this appeal to liberal communitarianism is, however, an ideal; but it is one which, even if not fully implemented, could serve as an important moral ideal for delivering policy and services.

Psychiatric professionals have a key role in developing the psychiatric community mentioned. Fundamentally, it is the role of psychiatric professionals to ensure the psychiatric communities *telos* is practically implemented. If, for example, the community decides that living wills are to be used, then the professionals will need to ensure that they are presenting this as an option to clients, discussing the implications of their use and making available the paperwork should a client wish to

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they share a number of convictions, most notably that humans are inevitably situated in and partly constituted by, historical communities and traditions.

use one. The psychiatric professionals are also required by the community to exhibit the kind of professional virtues that we have already mentioned.

A psychiatric community, as defined in this discussion, would be philosophically based on the idea of recovery as the *telos*. Exactly what this would mean would be something that the community would have to determine for itself. Given the conceptual understanding of recovery already developed, a psychiatric community will need to work within a recovery ethos in which virtue and narrative and are seen as co-equal constituents, since these contribute to the community in the sense already described. The last section of this chapter will indicate why these ingredients are so essential for developing a shared purpose or *telos*. Within the psychiatric community we can see that there will be many different services included. Some of those services, for example, crisis services and hospital based services, will usually be provided by psychiatric services, since this is where most of the professionals able to provide those services are currently found. Other services will target other parts of the illness-health continuum: some services focusing on rehabilitation; others on self-help, work and relationships. The range of services is considerable. Currently, these services are often delivered from alternative frames of reference and see more ground for disagreement than for agreement. A recovery ethos would provide that common philosophical underpinning. The following shows the strengths and weaknesses of using a liberal communitarian approach to developing a shared *telos*.

Strengths of a liberal communitarian model for developing a shared *telos*
(i) Resolving disagreements

A liberal procedural ethos has not provided adequate answers for disagreements in psychiatric and other mental health services, which is a major consideration given the disagreement on core principles between psychiatric and other mental health services in New Zealand. In many respects, the procedural ethos operates by papering over disagreements and providing a notional sense of a set of minimal conditions that everyone, regardless of their conception of the good life, can assent to. The problem is that people do not let go of their deepest convictions simply because there is a procedure which can prevent open disagreement and dissent. That deep set of values and beliefs will often try to find other ways of being heard, not always constructively.

The liberal communitarian approach, like the liberal approach, accepts that people will have differing conceptions of the good life. The liberal communitarian approach holds out the prospect that the best ideas within the psychiatric community can persuade others to adopt them and that this set of ideas will inform policy and protocols within the community. It is seen as a virtue that members of the community can participate in community decision-making through the various forums and committees which would be available. Indeed, such membership is an important ingredient in developing civic virtue, as we will see later. Toleration, like participation, is also an important virtue with such a liberal communitarian approach, since there will be many views on how to develop and implement the *telos*. Such a conception of the good life and its relationship to the community might make the good life appear a mechanical process applied to diverse issues. It might appear that once the *telos* is determined in terms of the recovery vision for that particular service within the psychiatric community (where differing aspects of recovery would be emphasised depending upon the recovery stage) policies, protocols and guidelines are established and there is nothing more to discuss or deliberate on. This would simply be incorrect. The good life in terms of the *telos* of the service is never settled and fixed. As Emmanuel (1991) says:

> a conception embodies a picture of human life that is but a sketch in need of specification and refinement. These details are added in the process of deliberation, whether that deliberation is abstract, about the conception of the good life itself, or whether it focuses on a specific policy and implicates refinement of the conception of the good life (p.213).

Specifying exactly what recovery means in terms of the service and the wider psychiatric community is subject to change simply because new clients have new needs and their stage of recovery will be different. The reality of being involved in a psychiatric community informed by a liberal communitarian approach, therefore, is that disagreements are more likely to be open and honest[10] with an appeal to some kind of decision-making process for particularly important decisions.

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[10] Ethical dissonance will still exist between psychiatric professionals and clients within a liberal communitarian approach but there will be a greater commitment to the virtues needed to resolve or work with that dissonance. By ethical dissonance, I refer to differences between the perspectives of clients and professionals in terms of how much responsibility it is believed clients can assume at any point in their recovery.

(ii) Participation

In a liberal communitarian approach, participation is a vital characteristic. Members of the community are not simply permitted to participate but actively encouraged to participate in all aspects of the community. Participation is important for several reasons. Firstly, the community needs to have a sense in which deliberation about important issues is occurring in order to identify the *telos* and the way it will be realised. Secondly, participation reflects the therapeutic goals of the psychiatric community, where clients assume increasing levels of responsibility and hence participation in the community's activities will have a therapeutic value. Thirdly, participation helps both professionals and clients to develop or reacquire civic virtues, and finally, participation is an important decision-making tool.

In emphasising participation in the way the liberal communitarian approach does, the community will have a sense of communal ownership of decisions and hopefully this will lead to a greater sense of social inclusion.

The liberal communitarian approach of the psychiatric community will also provide a necessary milieu for the collaborative model to achieve fruition, where full participation is seen as vital for enabling the expertise of professional and client to develop.

(iii) The client's voice and recovery narrative

A participatory community will also be one where the client's voice will be heard. The client's voice and the associated recovery narratives are, as already indicated, an important counter to the professionalisation of psychiatric services. The clients' voice and the associated recovery narratives will occur through the various administrative and deliberative structures of the psychiatric community. There are at least four ways that the client's voice will become prominent : 1) in the formal representation of clients at the various levels of the community, to ensure the client perspective is always heard; 2) through an increased focus on 'success' stories for clients to model themselves on; 3) in the development of policy and protocols in the community which reflect the client perspective; and 4) in becoming part of the voice of the community, particularly in terms of the interface with the public. At present the client voice and the professional voice are often presented by the media as being at odds. While disagreement will still exist in the liberal communitarian approach, there

will be an increased concordance between professionals and clients such that this will be represented (one hopes) in media profiles.

(iv) Socialising particular virtues

Virtues are learned, and in that sense practice in the virtues is indispensable. Learning takes place through parental, school and community influences, amongst others. Since communities have greater local control over the sort of organisation and culture they use and endorse under a liberal communitarian approach, the kinds of virtues and recovery narratives that assist recovery from mental illness – for both professionals and clients – can become emphasised and enculturated. Over time, these virtues will become the virtues that the community selects for, particularly in terms of its recruitment of psychiatric professionals.

(v) Sharing responsibility

One of the problems with the current organisation of psychiatric services is that professionals carry the bulk of responsibility *for some activities*. This leads in turn to professionals practising defensively and creating a risk averse culture that is itself harmful for the prospects of recovery, since in order to recover individual clients do need to take calculated risks. This emphasis upon professional responsibility spills over from psychiatric services into the general societal view that psychiatric services are absolutely responsible for someone once they are receiving any services from psychiatric services. This notion of responsibility is seen in categorical ways as meaning psychiatric services either are responsible (if a client is part of psychiatric services or historically received psychiatric services) or not responsible only when someone has never received psychiatric services.

In a psychiatric community, sharing responsibility is a way of ensuring shared agency between professionals and clients. May (1992) makes a case for membership of a group as a way of increasing social responsibility. May argues that people should see themselves as sharing responsibility for various harms perpetrated by, or occurring within their communities. This is a point with which I agree, particularly in the case of the current psychiatric services where both professionals and clients, in different ways, fail to adequately accept some responsibility. In the case of professionals, that lack of responsibility extends into the political and funding arena and the presentation of psychiatric issues to the general public. In the case of

clients, the failure to accept some responsibility for their own mental well being or aspects of their own mental well being.

Possible problems with a liberal communitarian approach

Impracticality

Introducing a liberal communitarian approach can appear hopelessly impractical. However, this appearance of impracticality is at least partly due to the idealistic nature of much of the liberal communitarian approach compared to what currently exists. There are real problems associated with introducing liberal communitarianism. The first is clarifying membership which would be difficult in the early phase of the community since people would be leaving and joining all the time. In principle, however, this is no different to the way citizens arrive and leave the country. It simply requires some means of keeping track of people's movements. Another problem would be how to develop a participatory method[11] for ensuring that values are shared. A third problem could be that participation and full deliberation of members would take more time than clinical services can provide. However, it must be remembered the issues that would receive full community discussion would not be individual clinical decisions, which would remain at the level of professionals and clients. Perhaps the most serious problem is that the mental state of clients can hinder participation. Particular mental states, such as psychosis, are not commensurate with assuming responsibility for voting or sharing community responsibility (or, we might add, with full citizenship[12]). It is for this reason that the community would need to agree – through a process of full discussion and deliberation – how clients who are seriously unwell would be dealt by the community. The community would need to assume that all members had full voting and participation rights, unless there were compelling reasons for their removal or suspension. Psychosis or intoxication would be such compelling reasons. In order to ensure that political considerations were minimised (that is removing discussion and possibly voting rights from people who disagreed with a particular policy direction, for example) it would be necessary to

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[11] Since any well functioning community has a shared goal, with shared values and shared tradition, the question for the liberal communitarian is whether it is possible to create such a community. Fortunately, in the case of the psychiatric community, those shared traditions already exist from which a shared set of values can be worked.

[12] See Sayce (2000) for more understanding of the practicalities of how recovery from mental illness connects to the notion of citizenship.

have such restrictions agreed in a quasi-legal process, perhaps involving both judges and clinicians.

The common *telos* which a liberal communitarian approach can provide is the essential basis of a psychiatric community and for such a community to start to see itself as a community. However, such a community needs to show how it can provide the essential basis for the virtues and the recovery narratives in a way which enables decisions to be made in a pluralistic manner.

Section Four: Implications of a Common *Telos*

The aim of this section is to show that having a common *telos* for the psychiatric community means that members of that community will need to adopt certain virtues and work with the notion of recovery narratives in order to facilitate recovery in a pluralistic way. The section starts with civic virtues since these are foundational, before considering pluralism and its connection to the psychiatric community.

Mental illness can mean that people are unable to participate in the community as citizens in the fullest sense. One way of understanding how the psychiatric community can help clients become fully citizens again is to use Aristotle's (1959) approach to civic virtues. Aristotle discusses civic virtue in the context of membership of a state, but there is an analogy with membership of a community that is pertinent to my discussion.

Aristotle thought those citizens in any state or community were members of a particular association. Citizens within that association have various duties to perform. However, while there are various duties, within the psychiatric community there is one common purpose, namely recovery. Civic virtue, according to Aristotle (1959, p. 71) must be relative to the constitution of the state or organisation. Being a good citizen for Aristotle is connected with both living in accordance with the *telos* of the group and with actively promoting the good of the state or organisation. The role of the psychiatric community is therefore to prepare clients for active citizenship in the fullest sense once they leave the community. Being a good citizen for Aristotle meant performing the duties of one's role within the state. Not everybody has the same duty, which is also true for the psychiatric community. In the psychiatric community, the role of the client is to attempt to recover from mental illness: the role of the psychiatric professional is to try and help clients to recover from mental illness.

There are also various offices within the constitution or community. Aristotle considered that while there were different types of citizens (depending on their role) a person who occupies those offices and honours of the state is a citizen in the higher sense.

People who are mentally ill are sometimes unable to fully participate in citizenship. For example, at the most basic level, people under the Mental Health Act are unable to vote in elections or participate in a jury. The psychiatric community has, therefore, two prime objectives in connection with civic virtue. Firstly, it is to provide an opportunity for members of the community to acquire the basic civic virtues that will enable them to participate as citizens in the community and the broader society. Secondly, it is to provide an opportunity, through participation, for members of the psychiatric community to obtain offices and honours within the community by which to fulfil the higher levels of citizenship mentioned by Aristotle.

The conception of recovery developed in Chapter 2 was one that saw it as focused on improvements in symptoms and functionality as the recovery criteria from both a client and professional perspective. However, recovery from mental illness needed to be seen in pluralistic terms in the sense of its facilitation. To reiterate, by pluralistic is meant that there are a variety of methods from biological, psychological and self help approaches which have their own particular merits and that recovery focused interventions involve identifying when one type of approach is more appropriate than another. This conception of recovery connects to the notion of a psychiatric community in three ways. Firstly, no psychiatric or other mental health service can deliver all of a recovery-focused service. Some services will focus on the crisis and acute part of the illness–health continuum and some will focus on rehabilitation or self care. They will all target different parts of the recovery experience. The recovery narrative that clients learn to tell themselves about these experiences, in collaboration with professionals, can help them connect to this psychiatric community in several ways. By having a common narrative for the imaginary ideal client in terms of which services are available for each part of the continuum, clients can assess their own experiences more usefully. Additionally, professionals can specialise in working with the experiences of clients in certain parts of the continuum. Secondly, while each service in the continuum will be aiming to do something different, they are all aiming at recovery as the *telos* of the service. Agreement about the *telos* will provide an overarching sense of purpose to the

psychiatric community and enable particular services (aimed at particular parts of the recovery narrative) to develop virtues in their professionals and clients pertinent to that stage of recovery. As we saw earlier, this involves developing civic virtues additional to moral and intellectual virtues. Thirdly, while client good is equated with recovery, and while client good is comprised of varying conceptions of client good, (such as Pellegrino and Thamasma's (1988)) it is important to recognise that in a psychiatric crisis it is sometimes necessary to overrule the client's consent. A pluralistic approach to facilitating recovery accepts that, on some occasions, professional interventions without reference to the client's wishes are necessary.

Pluralism, in the sense I have been using the term, connects the psychiatric community, the virtues and recovery narrative. It does this by recognising that there are many ways of facilitating recovery from mental illness. However, although there are many ways of facilitating recovery, there are ways that decisions about particular interventions or treatments can be made. Those decisions are not determined by procedures or by pragmatism but by particular virtues, moral, intellectual and civic, applied to the stage of recovery a client is currently in. The way particular virtues are connected to particular stages of the recovery narrative is determined by the psychiatric community and its liberal communitarian approach in which everyone can participate in a decision-making process through the development of civic virtues.

A final point about pluralism and the psychiatric community is that while predominantly it will be about biological, psychological, social and self help approaches, it will have the potential to be about much more. Traditionally, the biopsychosocial model has meant that psychiatric services have been eclectic predominantly in terms of biological, psychological and social interventions. When other approaches such as self help, culture and spirituality have been needed, they have been applied in an eclectic manner in line with the procedural ethos. Applying such interventions using eclectic procedures is less than helpful because eclectic procedures are unable to respond, in a flexible way, to individual needs.

Spirituality, perhaps more than any other area, shows the intrinsic weakness of the procedural ethos. While client narratives and the virtues will help clients and professionals to make decisions about which type of intervention is needed at any point, the psychiatric community will provide the overall basis for determining which goods should be pursued and what those goods *mean* to the individual. Decisions

involving meaning are central to any spiritual quest and such decisions simply cannot be left to procedures[13].

Summary

This chapter has discussed the basis of the recovery ethos in the need to develop a psychiatric community.

It has argued for an Aristotelian understanding of community, based on the notion of a shared set of values or *telos*. I provided a brief historical analysis of how the current procedural ethos had developed with its emphasis on the individual where there was no agreed values or *telos*.

The wholesale dismantling of the psychiatric asylum-based community that occurred with deinstitutionalisation has caused damage to very idea of a psychiatric community. While there is much about that 'community' which we may wish to abandon, the attempt to dismantle the 'community' which occurred during the deinstitutionalisation era was too sudden and wholesale. That attempt may have succeeded in formally destroying the 'community', but new services emerged to try and take its place. Unfortunately, this has resulted in a fragmentation of the psychiatric and other mental health services, all committed to different, and at times, conflicting, goods.

I argued that to develop a psychiatric community there would need to be a common *telos* but where there would be some local control over how that *telos* was reached. That *telos* would be the client's good that would be achieved through recovery from mental illness.

Liberal communitarian approaches are most likely to achieve the objectives of deliberation and participation that a psychiatric community would need to develop a shared *telos*. Liberal communitarian approaches, while respecting the individual, also see a need to respect the community as a whole. I indicated that the development of civic virtues and eventually citizenship, for clients recovering from mental illness, was an important role of the psychiatric community.

Finally, I indicated how a pluralistic approach to facilitating recovery was best achieved through a psychiatric community with its virtue and narrative components.

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[13] The tendency to resort to procedures is well illustrated by Ross (1994), who laments the lack of guidelines for spirituality.

CONCLUSION

       This thesis has presented a case for the development of the recovery ethos as the underpinning philosophy of psychiatric services. This case has not been an easy one to make since there has been no previous attempt to develop a systematic philosophy of psychiatric services based on recovery as opposed to either a philosophy of psychiatry or a philosophy of client empowerment ('the recovery approach' which I discussed in Chapter 2) which are both now familiar terms. Indeed, part of the problem in this regard is that psychiatric services have often seen themselves as not having an ethos, as being simply an instrumental service that pragmatically does the best it can for people with mental disorder. As I showed in Chapter 3 with regards the conceptual foundations of psychiatric services, and then subsequently in Chapters 4 and 5 with regards the procedural ethos, psychiatric services have adopted a procedural ethos as the underpinning approach to decision-making which *is an ethos* based on using eclectic procedures to treat mental disorder.

       The scope of this thesis was psychiatric services in New Zealand. The reason for the scope of psychiatric services is that this is where the largest payoff to developing a recovery ethos is to be found in terms of an impact on clients recovering from mental illness. However, as I indicated, a larger scope involving psychiatric and other mental health services together could also have focused upon developing a recovery ethos. At various points in the thesis that broader scope has been acknowledged and mentioned. Mention was made, for example, of the way a different type of procedural ethos operated in psychiatric and other mental health services (such as the private sector and non governmental organisations).

       This thesis began by identifying two questions to be answered. Why is the procedural ethos a problem for achieving recovery from mental illness in psychiatric services? How do we replace a procedural ethos with a recovery ethos?

       In order to answer the first question it was necessary to show that a procedural ethos is currently dominant within psychiatric services. In order to do this, an historical analysis was provided indicating the way that the ethos of psychiatric services has changed in the past two hundred years from superstitious, to utilitarian ethos and clinical-expert, to the current procedural ethos.

       The procedural ethos has become the *de facto* philosophy of psychiatric services in the past half century mostly in response to the liberalism in society more

generally. This liberalism has affected all areas of life, including both education and health. The main effect has been an increasing withdrawal by the state in promoting any one conception of the good life over another. In the context of psychiatric services, this has extended to a reluctance to promote any particular clinical school or approach over another and thus has emphasised procedures as a way of making decisions. This procedural emphasis has meant that the focus within psychiatric services has been on the need for psychiatric professionals to find consensus through procedures based around diagnosing and treating mental disorder. These procedures have used the eclecticism of the biopsychosocial model as a way of making decisions. Eclecticism stressed the way that the various health domains (biological, psychological, social) should be seen as equally important for each stage of a client's recovery based upon procedural justice. Eclecticism was contrasted, as a way of making decisions, with pluralism. Like eclecticism, pluralism accepts that the various domains are important, but unlike eclecticism, it does not see them as equally important for each stage of a client's recovery. Pluralism does not see client self help as another domain to be proceduralised but instead sees it in terms of the client assuming responsibility for aspects of their own health along the illness-health continuum. The 'recovery approach' which was the dominant client approach had itself become proceduralised, in that client self help was seen as simply another health domain to be treated as equally important to the others.

The procedures within psychiatric services were based on the principles of justice, autonomy and beneficence, with justice being the dominant principle. Psychiatric services were contrasted with other mental health services (excepting primary services) where autonomy was the dominant principle underpinning procedures. Within psychiatric services there has always been a strong, almost illiberal tradition of paternalism which created a particular type of service in response to the liberalism within the wider society. Unlike other liberal inspired services within society, psychiatric services (within the context of the legislative imperative) were allowed to place the principle of justice before those of autonomy or beneficence. This meant, in practice, that there was a conflict between the principle of justice and the 'recovery approach' which emphasised client empowerment and autonomy. This conflict was most evident between psychiatric services and other mental health services which did not have the same legislative imperative to contend with. This conflict was not resolvable using principle based theories, such as deontology or

utilitarianism, since they both fed into the procedural ethos. The most notable modern theory within healthcare using principles from both deontological and utilitarian traditions has been the four principles approach, which has also not succeeded in being able to resolve this longstanding problem of reconciling autonomy with the occasional need for paternalism.

The conceptual difficulties with the procedural ethos have resulted in a number of practical problems, which has not helped recovery from mental illness to occur. These range from a reliance on externalised decision-making to a lack of value placed on reflective practice. The implications of these problems have been that clients have not taken appropriate responsibility for aspects of their own health, which has undermined recovery and is why the thesis has emphasised how we could replace the procedural ethos with the recovery ethos as the second question we were attempting to answer.

In Chapter 2 the concept of recovery was clarified. The concept of recovery is a complex concept, which is why it is used in many different ways. It was argued that recovery was best understood as being concerned with improvement in mental health along the illness-health continuum. It was also argued that the recovery criteria included improvements in functioning and symptoms and that we need to understand this from both a client and professional perspective. Psychiatric services have a long tradition of fostering recovery (as we saw in Chapter 1), alternating between biologically and psychologically based approaches. The current 'recovery approach' which has been adopted formally by psychiatric services has sought to reject much of this historical legacy. In particular, it has tended to ignore or even dismiss the professional perspective, focusing instead on a client perspective towards symptoms and functioning. The result of this has been a tendency to see treatment and care connected with this biological approach as unhelpful, coercive or unethical. Psychiatric staff – particularly nurses and doctors who work mostly from such a biological perspective – have often found the adoption of the 'recovery approach' difficult and challenging and hence the relatively poor adoption by psychiatric services of a 'recovery approach', since so many professionals feel marginalized by it.

The thesis argued that recovery did merit being seen as the underlying ethos of psychiatric services but that, in order to include all the various professionals and clients, a more pluralistic approach to facilitating recovery was necessary than either

dogmatically seeing it in professional or client terms based on eclecticism. A pluralistic approach to facilitating recovery also countered the eclecticism of the biopsychosocial model which itself had fed the procedural ethos. It was indicated that the recovery ethos could apply to all mental illnesses with the degree of insight being the only complicating factor, which could be more affected in some illnesses than in others. Additionally, a broader conception of recovery was needed, based on the illness-health continuum, since recovery in theory could be seen as open-ended.

The thesis stressed the need for a changing emphasis for the conceptual basis of psychiatric services. This involved working out what disorder, illness, health and dysfunction meant and what their relationship might be. It was indicated that it was possible to have a view of recovery based on either a disorder conception or health conception (in Chapter 3) and that mental health needed to be seen as the primary conceptual foundation alongside mental illness. As already mentioned, recovery is best understood as occupying the illness-health continuum. Currently psychiatric services have a focus on mental disorder and with it an emphasis on professional skills in diagnosis and classification rather than how the client can help themselves. A crucial distinction was made between disorder and illness. Mental disorder was identified with the objectively identified signs and symptoms of the disorder whereas illness was seen as the client's response to that disorder. The changing emphasis upon mental illness, which is the client's response to mental disorder, would increase the client taking more responsibility for their own health where appropriate.

The thesis also rested on a functionalist philosophy of mind in which the mind was seen as emergent from the brain. This view was contrasted with qualia and reductive materialistic accounts of philosophy of mind and indicated that a functionalist/emergent philosophy was more conducive to understanding recovery.

Developing a recovery ethos to replace the procedural ethos provided the main thrust to the thesis. A recovery ethos involves all the possible components which are involved in a psychiatric service, that is the internal world of the client, the relationship between clients and professionals and the surrounding service and community. Hence the components of the recovery ethos, the virtues of clients and professionals, the client-professional virtue-based model, the recovery narrative of the client and the psychiatric community.

In order to recover from mental illness, it is necessary but not sufficient to have recovered from mental disorder. Once the disorder is under control, or at least manageable, the client can begin to recover from the broader problems incurred through mental illness. In order to recover from mental illness, both the client and psychiatric professional need to develop particular virtues: in the case of the client, virtues of hopefulness, self- awareness, compassion and trust, responsibility, courage, perseverance, collaboration, honesty, self discipline, and practical wisdom: in the case of psychiatric professionals, virtues connected to responsibility, loyalty, sympathy and compassion, genuineness, patience, tolerance, collaboration and practical wisdom.

Arising from these virtues, it was identified that there was a need for a collaborative virtue-based professional relationship, which would be based on the collaborative model of Pellegrino and Thomasma between client and professionals in order to maximise the professional and client virtues.

Clients will improve their chances of recovery from mental illness by developing a recovery narrative which enables them to make sense of their illness experience and find some kind of meaning in that illness experience. Constructing such a recovery narrative would enable clients to make best use of 'critical points' by learning when particular virtues could help move them forwards in their recovery and also by showing the way such a recovery narrative could help develop a collaborative relationship with psychiatric professionals.

The final component of the recovery ethos was the need for psychiatric services and the other mental health services to develop a psychiatric community which would form the basis for the recovery ethos so that the *telos* of recovery could become the ends of psychiatric care. I contrasted this with the current liberal procedural ethos where the ends are instrumental and hide the numerous disagreements and controversies in psychiatric care. The psychiatric community, through the development of an agreed *telos,* would indicate the moral, intellectual and civic virtues needed to reach that goal. Additionally, the psychiatric community would indicate what moral education, through client narratives, would be needed to support those virtues.

In conclusion, I return to the reminiscence with which this thesis began. By the adoption of a recovery ethos, the managers, clinicians, family and others involved in discussing 'recovery focused' services would have a clearer sense of what recovery

means and of how it could be achieved. I would hope that agreement could be achieved without the resort to procedures as the final decision-making approach.

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