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Mental Health Treatment Planning: A Dis/Empowering Process

Michael A. Mancini

Introduction

The model of mental health recovery has become a guiding vision for mental health services around the world (Hopper, Harrison, Janca, & Sartorius, 2007; Saxena & Setoya, 2014; Slade, Adams, & O'Hagan, 2012). Professionally derived definitions of recovery have focused more on clinical outcomes such as enhanced psychosocial functioning, reduced symptomology, decreased hospitalisation days, and increased stable housing (Moran, et al., 2014; Slade et al., 2012). Another definition of recovery is grounded in the narratives of psychiatric service users (Mead & Copeland, 2000). In this definition, recovery is defined as a personal journey of transformation from an illness-dominated identity marked by helplessness and hopelessness to a positive identity marked by meaning, self-determination, independence, and holistic well-being (Andresen, Oades, & Caputi, 2003; Anthony, 1993; Mancini, Hardiman, & Lawson, 2005).

In recent years, mental health systems around the world have moved to adopt practices that support both views of recovery. Psychiatric rehabilitation practices have emerged that assist persons with mental illness to develop the skills and resources needed to improve functioning across multiple domains that include independent living, employment, social relationships, wellness, and recreation (Corrigan, Mueser, Bond, Drake, & Solomon, 2009). Motivational interviewing has also emerged as a preferred style of therapeutic interaction in recovery-oriented organisations and systems (Miller & Rollnick, 2012). Practitioners of motivational interviewing eschew confrontational and interrogational styles of clinical interviewing in favour of a more open and evocative style that uses open-ended questions, reflections, and affirmations as a means to help people work through their ambivalence surrounding a particular behaviour in order to come to a shared conclusion about what to do (or not do) about an identified problem or concern (Miller & Rollnick, 2012).

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In addition, the emergence of recovery-oriented practices have sought to reduce the traditional power differential that exists between service users and providers by encouraging these actors to be collaborative partners and engage in a process of shared decision-making (Davidson, Rowe, Tondora, O'Connell, & Staeheli-Lawless, 2009; Deegan & Drake, 2006). Two areas where this is evident are in the practices of assessment and treatment planning which has become more strength-based and person-centred (Adams & Grieder, 2005; Rapp & Goscha, 2006). Traditional forms of assessment and treatment planning have involved professionals defining the problem (diagnosing), recording the problem in the official historical record (documentation), and then identifying (prescribing) relevant goals and outcomes and the treatments needed to achieve them. Professionals often determine goals with little active input from service users. These goals often involve reducing behaviours that professionals have deemed problematic or deviant (i.e., drug use, aggression). They also involve increasing behaviours seen as desirable, such as participation in therapy and compliance with medication regimens. These common goal-setting practices are contrary to the specific components of self-determination and choice inherent in the recovery model. Treatment planning that is recovery-oriented and person-centred requires that professionals engage in a negotiation of a shared understanding of 'problems', 'goals', and 'solutions' (Adams & Grieder, 2005). Shared decision-making requires that professionals listen and respect the desires and needs of service users. It also requires that service users take a more active role in their own treatment (Deegan & Drake, 2006).

Treatment planning as a social practice exists along a continuum of practices that include outreach and engagement, psychosocial assessment, and active treatment. In an idealised form, it is a means by which service user and provider identify relevant goals and map out their plan to achieve those goals in a specific time period. Treatment planning is both a product (i.e., a written official, signed document) and a process that consists of discursive interactions influenced by power, structure, and positioning of actors (Mancini, 2011).

While treatment planning has the potential to lead to positive transformation of the individual, it is an activity that is often dominated by professional treatment or therapy discourse. These discourses can position a service user's emotions, thoughts, and behaviours as problems to be evaluated, managed, and monitored as they move from a sub-optimal state to a more optimised condition as defined by professionals (Illouz, 2008). Furthermore, treatment planning is an activity that is monitored closely by third-party payers of psychiatric services such as state or federal governments or managed care insurance companies. These entities often decide what treatment goals are 'appropriate' and eligible for funding. This monitoring has led to a medicalisation of common physical and social states such as sadness, grief, rudeness, and apathy among others (Conrad, 2005).

Treatment planning, like any social practice, can be both transformative in some ways and oppressive in others. While much has been written about practices and concepts that comprise recovery, little has been written about how the recovery process may also be socially constructed through discursive practices. The question remains, what are the discursive practices that comprise recovery-oriented treatment planning?

I use critical discourse analysis (CDA) to explore this question. CDA is grounded in the assumption that social identities and power relations between persons, groups, and systems are created, reproduced, and transformed through discursive practices (Fairclough, 1995). Fairclough (1995) refers to 'orders of discourse' as a means for examining power dynamics within social practices. The orders of discourse represent the ways people interact, represent, and position themselves through discourse. From a CDA perspective, treatment planning is a social practice where the identities of service users and providers are established, reproduced, disrupted, and possibly transformed.

Project overview

This chapter draws on data from a three-year ethnographic action research project within a community mental health centre in a mid-sized metropolitan city in the United States. One of the goals of the broader action research study was to assist social work practitioners in adopting recovery-oriented assessment and treatment planning practices in their day-to-day activities through the establishment of a community of practice called the Co-Occurring Treatment Team (COTT) (Mancini, 2011; Mancini & Miner, 2013).

The COTT consisted of community mental health practitioners who were interested in being early adopters of assessment, treatment planning, and treatment practices that were designed to be more collaborative and to practice in such way as to position clients as experts in their own recovery rather than as problems or cases to be managed. As a co-member of COTT, the author and the COTT team leader worked closely with a cross-section of service providers from each of the community support teams at the agency in weekly two-hour sessions for a three-year period. Two separate COTTs were established. The first COTT (n = 10) met for two years. The second COTT (n = 14) met for one year. Each session was recorded. Following the principles of participatory action research (PAR) (Kemmis & McTaggart, 1988; Stringer, 2007) and the Communities of Practice model (Wenger, 1998), the COTT was designed to be a safe place of problem-based learning, critical reflection, and action.

Over the course of the study the author collected data in the form of field observations, interviews, and organisational documents (e.g., meeting minutes, policy statements, forms). During weekly COTT meetings, members were placed in the role of 'co-enquirer' through reflective and educational case

presentations from their caseload. Rather than focus on a service user's deficits and what they 'should' be doing, COTT members would first describe a service user's strengths and then they would describe a current challenge they have related to their practice with the client. They and the team would then brainstorm recovery-oriented solutions and next steps. As part of the discussion, members would challenge each other's use of language, intervention strategy, and how they positioned the service user in order to provide support and reinforce each other's use of recovery-oriented language and social practices.

The focus of this chapter will be on a single, one-time meeting between the COTT and Arthur (a pseudonym), a long-time service user of the agency where the study took place. Arthur's caseworker, Jessica (also a pseudonym), requests consultation from the COTT on how best to help Arthur engage in healthier and less disruptive behaviours. Jessica is a former COTT member from a previous cohort that concluded the previous year. She is familiar with the methods of COTT and the format of the meetings. She has been Arthur's caseworker for one to two years and has a strong therapeutic relationship with him. She encouraged Arthur to attend the COTT and also provided incentives in the form of lunch and release of some of his funds. Anecdotally, she has expressed frustration in regard to Arthur's behaviours and fears that he may be evicted from the programme. Given her knowledge of the COTT, she hopes that the COTT might provide a means by which Arthur can identify activities that would help him avoid eviction.

This meeting was chosen for analysis because it represents the only time an actual service user met with the COTT for consultation. COTT practices were usually practiced using vignettes, case records, or second-hand descriptions of actual service users provided by COTT members or other case workers from the agency. Arthur provided an opportunity to see the methods utilised by the COTT in action.

Collaborators

The COTT consisted of 12 community mental health caseworkers and two clinical supervisors. About half had bachelor's degrees while the other half had master's degrees in a helping profession (i.e., social work, counselling). Four members of the team were African American, while the rest were Caucasian. Four of the members were men, while the rest were women. The team leader was a white male with a master's in counselling, while the author was a white male with a master's and PhD in social work. The age of the COTT members ranged from mid-twenties to early fifties. Approximately a third were under 30. The experience of the COTT members also varied, with about half of the COTT members having approximately five years of experience in the mental health field. Some members had ten or more years of experience.

Arthur, the focus of the COTT's interview, is a single, gay, white man in his mid- to late forties. He has been receiving services from the agency for many years and is well known to many on the COTT. He lives in an apartment programme that provides independent housing and on-site support services to approximately 18 residents diagnosed with mental illnesses and addictions. Arthur is HIV positive and has been diagnosed with a serious mental illness, cerebral palsy, and an addiction to crack cocaine. He enjoys cooking, doing arts and crafts (i.e., making jewellery, pottery), and helping out at the agency (i.e., running errands, cleaning). COTT members have described him as a 'sweet guy' when he is not engaged in disruptive behaviours that they attribute to his addiction and mental illness diagnoses.

The reason for the consultation is that Arthur has been engaged in behaviours seen as dangerous and problematic by his caseworkers and the apartment programme staff. The behaviours in question include alleged sex work in exchange for drugs or money to buy drugs, frequent crack cocaine use, panhandling, drug buying in dangerous neighbourhoods, and verbal and physical altercations with other residents at the apartment complex and programme staff. Many of the altercations involve profanity and the use of racist and misogynistic language towards staff and residents. He is on the verge of being evicted due to his lack of participation in treatment, medication noncompliance, his deteriorating health, and disruptive behaviour. If released from this programme, it has been discussed that he will either be homeless or placed in a secure nursing facility. The goal of the consultation according to his primary caseworker is to find healthier ways for Arthur to spend his time (e.g., treatment participation, attending arts and crafts workshops, helping out at the club, exercising) so that he may reduce his problematic behaviours and stay in the programme. Boredom and lack of structure have been identified by his caseworker as a reason for his behaviour. Arthur himself identifies grief and depression due to loss of family members and loved ones as a reason for his drug use. He acknowledges some of his disruptive behaviours and identifies areas in which he has improved, particularly in relation to his reduced involvement in drug-using behaviours (i.e., being a 'runner' or someone who takes money and gets drugs for others) within the apartment complex and a reduction in verbal outbursts towards staff. He identifies cooking, helping out with odd jobs at the agency, and doing arts and craft projects such as making jewellery as preferred activities.

Arthur's caseworker Jessica explains to the COTT that she and Arthur agreed to come at her request to brainstorm ideas to lead a healthier life. However, it is not entirely clear that Arthur has freely chosen to come before the COTT. Arthur's caseworker, who has power over his money and living arrangement, directed him to attend and allowed him to have $15 of his own disability stipend to meet with the COTT. This was revealed during a meeting between

the caseworker and the COTT prior to Arthur's entrance. He may also be simply appeasing his caseworker, whom he obviously respects and admires, or he may recognise that this is something that he must do in order to satisfy the 'powers that be' at the apartment complex. In any case, the inherent hierarchical nature of a client meeting with a large group of professional caseworkers should be noted.

CDA methodology

CDA is used to explore the discursive practices that occur within a single treatment-planning meeting between the COTT and Arthur. Critical social theory provides the theoretical foundation for CDA. Critical social theory focuses on how oppression and domination is constructed, reproduced, and transformed through social practices and structures (Agger, 2006; Horkheimer, 1972). This set of theories focuses on the empowerment of oppressed individuals and groups through critical reflection and action (Agger, 2006). Through this foundation, CDA researchers critically analyse power relations and explicitly resist the domination of oppressed groups by seeking to transform relationships and practices that contribute to their domination (Blommaert, 2005; Rogers, 2011; van Dijk, 1993).

A central component of CDA is how discourses create, reproduce, and disrupt power relations and social identities between individuals and social systems (Fairclough, 1995). It is proposed that social practices such as treatment planning are made up of discourses that are dialectically linked to broader ideologies and social structures (Fairclough, 2003). Discourses can influence, and are influenced by, the beliefs, actions, and values of the social actors involved in a particular social practice (i.e., service users and providers). The impact of these discourses may also be veiled (Fairclough, 1995).

Norman Fairclough (1995) proposes using the 'orders of discourse' to deconstruct these veiled power dynamics. The orders of discourse include (1) ways of interacting or genres; (2) ways of being or styles; and (3) ways of representing or discourses. Ways of interacting, or genres, are the texts and discourses that give structure to social practices (e.g., diagnostic meeting, treatment planning interview, and case consultation). Ways of being, or styles, refers to the positions, roles, and identities people take on during participation in a social practice (e.g., service user, client, professional, provider, team leader, and patient). Ways of representing, or discourses, are the underlying socio-political ideologies that give rise to identities and positionalities within a particular social practice (e.g., psychiatry, recovery, academia, medicine, social work, patienthood, and resistance). Analysis of the relationship within and between the orders of discourse can unlock a deeper understanding of the relationships between discourses and social practices (Fairclough, 1995).

Interpretations

The meeting that is the subject of this chapter consisted of a 45-minute exchange between Arthur, the COTT, and Jessica, his caseworker. This meeting aimed to put into practice the tenets of a recovery model of treatment planning. Using a CDA framework, I analysed the genre (e.g., turn taking, repetition, cohesive devices, and argument structure), discourses (e.g., lexical choices used to express ideas, themes, and counter-narratives), and styles or stances (e.g., modality, affect, and amplification) in each section of the meeting and provided illustrative excerpts from each section. In doing so, I describe, interpret, and explain how service providers and service users negotiate and renegotiate social understanding of 'the problems' and their 'solutions'.

For instance, the COTT intended to use motivational interviewing (Miller & Rollnick, 2012), an open, evocative style of interacting that positions the service user as the guide for the meeting. During the meeting I show that this genre shifted at times to a more disempowering interrogational genre of interaction with detrimental effects to the tone of the meeting. I also show how the team reacted to the tension and how the interaction shifted back to a more motivational interviewing genre. Lastly, I show how Arthur's position (style) in the meeting fluctuated. At some points in the meeting, Arthur was positioned as a traditional, passive 'patient' or 'client', whereas at other times he was positioned as an expert and, ultimately, the decision-maker when it came to his behaviours. I later discuss implications for the institutional structures, procedures, and policies that impact how recovery-oriented practices are implemented and its effects on service users and providers.

Recovery, motivational interviewing, and Arthur

At the opening of the meeting Arthur comes in and sits at the head of the table. The tone is light and conversational. Following introductions, Arthur's case worker, Jessica, explains that she and Arthur agreed to come to the COTT on her suggestion in order to explore ways that Arthur can engage in behaviours that his caseworkers and apartment staff would see as healthier and less dangerous. Following this explanation the team proceeds to ask Arthur a series of questions that are geared to get him to talk about how he can be healthier and safer. In many ways, this portion of the meeting aligned with the genre and discourse of institutional psychiatry. For instance, the directionality of the questioning is one way as only the team is allowed to ask Arthur any questions. Arthur does not ask the team any questions, nor is he invited to. Arthur and his problematic behaviours are the sole subject of the meeting. The team does not share any personal information about themselves with Arthur. This one-way flow of information is representative of an institutional discourse of psychiatry due to the heavy emphasis on social control of deviant behaviours (i.e.,

outbursts, drug use, panhandling) and the need to develop healthier behaviours and activities that are more acceptable (see, e.g., O'Reilly & Lester, Introduction, this volume)

It is only when a motivational interviewing genre is intentionally practiced by the team leader that a recovery discourse begins to emerge. Motivational interviewing (Miller & Rollnick, 2012) is a non-confrontational style of clinical interaction that relies on evocative, open-ended questions, reflections, and affirmations that seek to explore areas of common ground. This choice of genre results in the emergence of a recovery discourse. I define a recovery discourse as social practices that position Arthur as a collaborative partner in the treatment planning process and focus on the factors that would contribute to his holistic well-being as a person, rather than solely symptoms or problematic behaviours. Rather than focus on what Arthur is doing 'wrong', the discourse of the question attempts to define what Arthur sees as relevant to his own happiness. At no point in the meeting when this genre is practiced is Arthur told what he 'should' do with his time. Rather, the team tries to engage in a conversation with Arthur about his interests and pleasures as well as about what aspects of his life have been difficult and what he would like to do differently. Extract 1 provides an example of this mixing of motivational interview genre and recovery discourse.

Extract 1

1 **Team Leader**: I was kind of curious...when things are going good for you
2 what's going on in your life?
3 **Arthur**: [10 second pause] I'd probably have a boyfriend.
4 **Team Leader**: I'm sorry?
5 **Arthur**: I said I'd probably have a boyfriend that's what I said.
6 **Team Leader**: OK...so having a boyfriend...So Arthur...being in a
7 relationship with somebody is important and so what are some other
8 things that help you find yourself at the happiest or doing better
9 besides...
10 **Arthur**: (interrupting)...I really can't feel no happiness. Everybody's
11 gone. I mean my grandma's 90 years old, my grandfather died on my
12 mom's side. My aunts, my uncles on my mom's side [died] and it's hard
13 to get over it. I mean I tried to get over them sometimes I cry myself
14 to sleep. But it don't do no good it just comes back. The guilt is
15 right there. So...
16 **Caseworker 2**: So what do you do to deal with all that sadness and
17 guilt?
18 **Arthur**: I try to talk to somebody or and it works sometimes but I
19 can't deal with it. Something about death I cannot...it's just there and
20 I'm afraid to let it show

In Extract 1, the team asks Arthur specifically what would make him happy (lines 1 and 2), and he responds candidly that he would like a 'boyfriend' (line 3). While his interest in a romantic relationship is recognised in lines 6 and 7, it is never brought up again and neither the COTT, nor Arthur further explores it. In fact, his first response is not even recognised (line 4) and so he repeats it again, rather forcefully with an added clarifier 'That's what I said' in line 5. While Arthur states what he thinks would relate to happiness does not directly answer the specific question asked by the team leader, it is an opportunity for exploration that is lost. So, while the use of a motivational interviewing/conversational genre opens up opportunities for exploration of something that Arthur finds important (e.g., having a boyfriend), some of those opportunities may have been shut down by the representational discourse of institutional psychiatry since they didn't align with what the COTT professionals deemed as relevant to treatment. Arthur then states in lines 10–15 the reasons he can't feel happiness is due to his despair, grief, and guilt. After being asked how he deals with this (lines 16–17), he states that he talks to someone (lines 18–20). Later in Extract 2 he states that this despair is the reason he uses drugs. In this extract, discourses of recovery and institutional psychiatry are both represented. For instance, while the questioning attempts to ascertain what Arthur sees as important in his own recovery (recovery discourse) the entire meeting is mainly dedicated to three areas: (1) to structure Arthur's day around what the team sees as healthier behaviours, such as attending arts and craft workshops, social groups, working, and exercising at the gym; (2) changing his interactional style with other residents and staff to be more compliant; and (3) engaging in less risky behaviours. The team's questions and probes are all geared towards changing Arthur's behaviours. In this way, recovery and institutional discourses exist in a hybrid fashion due to the intentional use of a motivational interviewing, a genre associated with the recovery model of mental health.

Arthur's interactional pattern throughout the meeting might be characterised as humorous and conversational. He relies on long, winding narratives about his life and his past experiences to any questions that are non-directive. In at least half a dozen sequences Arthur tells long narratives regarding a particular aspect of the question he is asked. For example, one of Arthur's behaviours that were identified as problematic is his selling of his food for money, presumably to buy crack cocaine. When asked a leading question of whether he is eating enough, Arthur states that he does and then goes into a story about how he almost set his kitchen on fire, eliciting laughter from the group.

Through his use of narratives, Arthur is able to use the soft, open, and non-confrontational motivational interviewing genre of the COTT against itself, jujitsu-style, resulting in much of the meeting being dedicated to listening

to stories by Arthur. As the meeting progresses in this fashion, the frustration of COTT members, who cannot make any progress towards the goals they set for the meeting, begins to grow. Arthur, in a sense, takes over the meeting and his positioning becomes more empowered. Interestingly, as Arthur's position within the meeting becomes more empowered, the tension within the COTT also grows as evidenced by long pauses, rigid body language, shifting, downward eyes, and head shaking. Arthur's position in the meeting is one of decision-maker. The choice of genre (motivational interviewing) has not only led to the emergence of a recovery discourse as noted above but also effectively altered the position of Arthur to be more empowered. Consequently, we see that Arthur resists 'collaborating' with COTT members to develop a plan to change the lifestyle patterns that the COTT has identified as problematic, presumably because he does not see his behaviours as they do.

The re-emergence of institutional discourses and genres

Despite the intended focus on recovery, in many ways, the underlying discourse throughout the meeting was aligned with traditional psychiatry whereby mental health professionals exercise power over identified 'patients' by diagnosing problems, identifying 'appropriate' or socially acceptable and institutionally defined goals, and prescribing treatment plans in order to correct inappropriate or deviant behaviour. When a motivational interviewing genre is intentionally implemented, does the discourse become more recovery-oriented? When this genre is abandoned, there is a re-emergence of a more institutional psychiatric discourse.

For example, approximately two-thirds of the way through the interview with Arthur there is a shift in genre and a resulting tension point in the meeting. Extract 2 shows a shift from a conversational/motivational genre to an interrogatory/confrontational genre (lines 1–5). It begins with an enquiry by a caseworker into Arthur's use of money obtained from his work at a fast-food restaurant (line 3). His work, which is explained in another segment, consists of panhandling, searching for lost change at the drive through window and opening doors for people in exchange for a quarter.

Extract 2

1 **Case Worker 3**: are you still working at white castle?

2 **Arthur**: Off and On. Off and on.

3 **Case Worker 3**: What do you do with the money you earn from there?

4 **Arthur**: (5 second pause)

5 **Case Worker 3**: Come on Arthur!

6 **Arthur**: (7 second pause)

7 **Case Worker 3**: Arthur, I appreciate you coming in here and I am not trying to put you on the

8 spot you know and I'm here and I'm here to help you and we're buddies
9 **Arthur**: . . . I'll be honest.
10 **Caseworker 6:** [overlapping with case worker 1 and 3] I know.
11 **Caseworker 1 (Jessica)**: You're doing a good job Arthur (several people supportive).
12 **Caseworker 3**: No that's cool. Thank you. I didn't want to put you on the spot.
13 **Case Worker 6**: It's ok, We're being generous here. Yeah I know.
14 **Arthur**. I mean get so tired hearing about it you know but I told Jessica [Arthur's caseworker] I
15 only smoke [crack cocaine] 1 o'clock at night. And then I calm down. Stay in my room for a
16 little bit. Real quiet and nice air conditioner and sometimes I come down to eat. Fix my own food
17 and . . . and . . . I love to cook.

In Extract 2, a case worker confronts Arthur forcibly on what he does with his money (line 5), insinuating that he spends the money he earns panhandling at White Castle on crack cocaine. The tone in line 3 is interrogatory and then confrontational in line 5 to the point that it borders on aggressive and is out of step with the rest of the interview. The caseworker is clearly frustrated about the way the interview is proceeding and tries to disrupt the status quo with a shift in interactional style towards brief confrontation. It is a disempowering statement that is rife with domination and hierarchy. For example, it would never occur to anyone in the room to openly ask a COTT member what they do with their earned money.

The result is 12 seconds of silence by Arthur (lines 4 and 6). At this point, the caseworker attempts to self-correct in lines 7–8 by thanking Arthur for coming to the meeting and implying that they are 'buddies'. The caseworker also defines his relationship with Arthur as a mutual friendship (i.e., buddies), ignoring the inherent power differential between the roles of provider and user of services. They are 'buddies' because the caseworker says so. Arthur is told that he knows this relationship exists, despite never being consulted on the matter. It may also be that the caseworker was perhaps demonstrating to the rest of the COTT that the caseworker's style of questioning is appropriate since they have some kind of deeper relationship that allows such questioning.

But perhaps most profoundly, the caseworker also states that he was not intentionally trying to pressure Arthur or put him 'on the spot' despite this being the end result (lines 7, 8, and 12). The caseworker also states that 'I'm here to help you' in line 8. This seemingly innocuous statement is perhaps the central component of the discourse of institutional psychiatry/social control, both currently and historically. It is a statement that implies that mental health professionals are sanctioned to engage in hegemonic practices that are coercive, humiliating, intrusive, rude, and sometimes violent against service users because it is what is necessary to 'help' the person with a diagnosed mental illness who, presumably, doesn't know any better. In short, it

is 'for their own good'. It is the essence of the good intentioned paternalism that proponents of the recovery model claim actually does more harm than good.

Arthur finally makes a defensive stand ('I get so tired of hearing it'). Several COTT members then rush to support him in lines 10–13 ('You're doing a good job Arthur'). There is a hybridity in that the two opposing genres are being expressed almost simultaneously. The result is tension within the room marked by silence from most COTT members and uncomfortable shifting and eye contact. Caseworkers strive to restore the original genre of motivational interviewing. Interestingly, after all this, Arthur seems to offer a confession about his use in lines 14–17. He provides a frank explanation as to the reason he uses crack (i.e., to relieve pressure and heartache) in a candid and open dialogue. The statements of reassuring from COTT members also contain a seed of paternalism since they offer evaluative judgement on Arthur's performance in the meeting. The COTT's performance, of course, is not open to scrutiny. The motivational interviewing genre is then restored for the remainder of the meeting.

One observation here is that the discourse of the meeting and the position of Arthur shifted as the genre of the meeting changed. When the team members used motivational interviewing, the discourse was more recovery-oriented, Arthur's position was more powerful and the ability of the COTT to influence him was diminished. As the genre shifted to a more disempowering, interrogation style of interviewing, the discourse of the institution prevailed and Arthur's position was less powerful.

The restoration of recovery-oriented discursive practices

Arthur's position within the COTT meeting is hybridised between a traditional 'client' or 'patient' and being a decision-maker. This hybridisation is not surprising given the clash between institutionalised psychiatric versus recovery discourses, as well as a motivational interviewing versus interactional patterns that are more interrogatory. However, because of the motivational nature of the interview genre and the COTT's attempted integration of the recovery model, Arthur is ultimately free to make his own decisions regarding the suggestions of the COTT and his schedule. He is free to deny the COTT any treatment goals or plans. He is free to choose whether he will engage in activities that are more healthy and 'appropriate' or continue with the status quo. In this sense, Arthur is positioned as having final decision-making power within the treatment planning meeting. For instance, when asked directly towards the end of the meeting to engage more regularly in arts and crafts, Arthur passively denies this request by stating, 'I have too much to do on Tuesdays.' When pressured again to potentially rearrange his grocery shopping day to attend arts and crafts, Arthur more forcefully states, 'I'd rather have 2 days off instead of doin''

[arts and] crafts. I do enough. (Jessica: OK). I do enough at home.' Arthur is positioned as in control of his own behaviours. The team, by design, does not confront Arthur and tell him what to do. They, as a sign of respect, try simply to problem-solve issues with him. Extract 3 occurs at the end of the interview after the team has re-established a motivational interviewing genre and Arthur regains his positioning as a decision-maker.

Extract 3

1 **Team Leader**: So Arthur, given all this, is there anything in your life
2 right now you want to be different?
3 **Arthur**: No. Everything's fine.
4 **Team Leader**: Arthur, I don't know if this question is confusing but
5 when as I asked if you want anything to be different (D: No) and you
6 said 'no everything is cool' but it sounds like some of the people in
7 your life are saying 'we're concerned about your health, your safety,'
8 and I am curious, things are cool, when you look at them you're saying
9 I'm cool but I'm wondering how you could help them help b/c it sounds
10 like they're saying 'we want Arthur to be a little more healthy, a
11 little safer,' is there anything you could partner with them on to do
12 some of that stuff.
13 **Arthur**: No.
14 **Team Leader**: No?
15 **Arthur**: No. I'll do it on my own.

Extract 3 represents the last interaction between Arthur and the team. He is asked a final time in lines 1 and 2 about what he would like in his life to be different. He responds quite convincingly that he would like nothing to be different in line 3. The team leader tries a second and third time to appeal to Arthur in lines 4 through 12, stating that perhaps Arthur did not understand the question in line 4. Because the team has determined that something is wrong, it is unthinkable that Arthur could possibly not want anything to be different. Arthur responds 'no' again in line 5. In line 6 through 12, the team leader, in a remarkably open statement reflecting the motivational interviewing genre, states plainly the team's concerns about Arthur's behaviour and, positioning Arthur again as the decision-maker, asks him to identify areas where he could collaborate with the team to help ease their concerns over his behaviour in lines 9–12. This statement positions Arthur as a partner and equal member of the team. The open question allows Arthur to refuse or choose to collaborate and also asks Arthur to choose how he would collaborate. This statement embodies the shared decision-making approach that is embedded in recovery-oriented practice. In lines 3, 5, 13, and 15 Arthur denies the

team leader and states at the end that he will do 'it' on his own. 'It' is never defined.

Clinical relevance summary

Putting into practice a recovery model of treatment planning is complex. This complexity is, in part, due to the long-standing genres, discourses, and styles that permeate institutional psychiatry. This chapter has focused on what happens when a recovery-oriented group of practitioners attempt to put into practice discursive strategies designed to empower a single service user. The COTT's efforts, led by their team leader, to adopt a more open and evocative interviewing genre as their mode of interaction and to intentionally position service users as collaborative partners disrupted the traditional power relations that impact treatment planning and other mental health practices. In this instance, the more recovery-oriented positionality produced a situation where goals were not developed, leading not only to frustration by some workers but also a recognition that they perhaps need to work harder to engage Arthur in a working alliance.

It has been suggested that mental health casework is inherently hegemonic with a goal of social control of the minds and bodies of the psychiatrically disabled through surveillance and the management of increasingly medicalised physical or emotional states (Conrad, 2005; Foucault, 1977). For instance, in Arthur's case, his caloric consumption, leisure time, and social behaviour have all been transformed into treatment targets to be monitored and managed by professionals. This management will undoubtedly involve codification within the treatment plan and ongoing surveillance by the team.

The mental health literature is rife with accounts of domination of service users at the hands of institutional psychiatry. Disempowerment is woven into the fabric of the institutional discourses (Whitaker, 2010). Recent research suggests that social control is often expressed by healthcare workers and is inherent in their positions and training, which can lead to client disempowerment. This is particularly the case when clients are seen to be resisting, contesting or evading treatment (Hazelton & Rossiter, Chapter 21, this volume). Intentionally focusing on social communication between client and workers can disrupt these dynamics (Lawn, Delany, Sweet, Battersby, & Skinner, 2014).

Other research has indicated that a strong relationship between service user and provider is the basis for enhancing personal recovery (Horvath, 2005; Moran et al., 2014; Priebe & McCabe, 2008). Providers' ability to engage in recovery-oriented strategies such as enhancing hope and self-acceptance as well as an ability to be empathic and respectful has been shown to impact a person's recovery (Russinova, Rogers, Ellison, & Lyass, 2011).

Interrupting the ways service uses and providers interact and position themselves may be an opportunity to establish a more helpful and respectful working alliance.

The data from this project support three approaches that may assist in the implementation of more recovery-oriented practices. The first is the development of design teams of agency leaders and staff that wish to engage in an extended process of critical enquiry into their practices. Agencies can set up policies and procedures to assist spreading the work of these teams across the agency (Mancini & Miner, 2013). A second is for agencies to develop collaborative partnerships with engaged scholars that can assist case workers and team leaders in engaging in a process of critical and reflexive enquiry into their own practices. The author's prolonged engagement with the organisation assisted COTT members to utilise CDA in order to develop a process by which they could critically reflect upon their practices from a recovery standpoint. This form of engaged scholarship (Boyer, 1990; Van de Ven, 2007) also shaped the researcher's own knowledge and practice and enabled him to share those experiences in the classroom through guest lectures from practitioners and clients involved in the COTT. This created a relationship whereby the practices of caseworkers, researchers and pre-service social workers were all transformed through the critical enquiry process.

Lastly, and perhaps most importantly, mental health organisations can challenge disempowering discursive practices that are inherent in mental health casework by routinely integrating certified peer specialists into treatment teams with clear and enhanced roles. Certified peer specialists are persons who have a history of psychiatric disability and recovery (i.e., service users) and work to help others in their recovery process (Solomon, 2004). Peer specialists, also called 'consumer-providers', have been identified as a key need in the community mental health arena along with the provision of consumer-operated programming in North America (Drake & Latimer, 2012). They bring a unique perspective of a lived experience of mental illness and recovery. They also have experienced first-hand the disempowering and often veiled social practices of mental health professionals that can lead to despair and hopelessness that the COTT was designed to disrupt. They can unveil and transform the taken-for-granted assumptions of treatment teams that reproduce oppressive practices, thereby making them less hegemonic and more sensitive to the practices that can lead to enhanced working alliances. Service users, individually and through organised social action groups, have long disrupted the dominant psychiatric discourse. Having them integrated within treatment teams may help to dismantle the psychiatric discourses that are inherent in the discursive practices of treatment planning leading to a transformation of ideology and practice at the interaction level and beyond. For a simple summary of the practical implications, please see Table 18.1

Table 18.1 Clinical practice highlights

1. Recovery-oriented practice requires practitioners to disrupt disempowering practices that have been institutionalised.
2. Implementing more open and evocative forms of interactional genre's can lead to the disruption of disempowering discourses and practices, while repositioning service users as empowered participants in their own recoveries.
3. Establishing design teams that engage in a process of critical reflection and action can lead to more recovery-oriented practices within community mental health agencies.
4. Collaboration with engaged scholars and the integration of certified peer specialists into mental health casework teams can lead to a transformation of mental health practices at multiple levels.

Summary

The emergence of the recovery model as a guiding vision for mental health treatment systems around the world is a welcome development given the brutality faced by those diagnosed with psychiatric disabilities both historically and currently. However, acknowledgement of the importance of this vision at the policy level is not enough. A warm, respectful, egalitarian working alliance between service user and provider represents one of the main sources of recovery for people diagnosed with psychiatric disabilities (Moran et al., 2014, Russinova et al., 2011). The development of this type of relationship requires the critical analysis and disruption of the traditional power relationships between service user and provider at the interactional level. The effective implementation of recovery-oriented theories and practices in the day-to-day routines of community mental health caseworkers requires practitioners to engage in an extended process of critical enquiry into the social and discursive practices of assessment, planning and treatment.

Accomplishing this requires systems, organisations, and professional education programmes to provide the tools, resources, and encouragement necessary to assist caseworkers engaging in this process. The emergence of recovery as the guiding practice of community mental health requires the involvement of all those impacted across the practice landscape. Therefore, projects designed to transform structures and policies to be more recovery-oriented must be forged by collaborations between community mental health practitioners, administrators, academic scholars, and service users. Methodologies of critical enquiry such as CDA offer important tools that can be utilised to uncover and disrupt disempowering practices and, ultimately, provide the very strategies needed to transform them.

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