INTRODUCTION

OUTLINE OF THE CURRENT PROBLEM

> Nowadays the most horrible disease is not leprosy or tuberculosis: it is the feeling to be undesirable, rejected, uncared for and abandoned by all (This statement is on a wall in one of Mother Theresa's mission houses).

In 1991, The United Nations Resolution on the Protection of Persons with a Mental Illness (United Nations General Assembly, 1991) stated that the rights of people accessing mental health services were the same as rights for all people. These rights included the right to participate in the treatment, planning, design, delivery and evaluation of services received. The Australian State ministers agreed to a Statement of Rights and Responsibilities for persons with mental illness, in response to this declaration (Commonwealth of Australia, 1995). This document introduced the philosophy of civil and human rights into the National Mental Health Policy. In April 1992 the national health ministers endorsed The First National Mental Health Plan, establishing a collaborative framework for the National Mental Health Strategy to proceed (Australian Health Ministers, 1995; Commonwealth of Australia, 1992; Commonwealth of Australia, 1995).

The First National Mental Health Strategy was 'designed to improve mental health outcomes for individuals and the community over the period 1992-98' and was completed in 1998 (Commonwealth Department of Health and Aged Care, 1998: 2). These policy initiatives introduced many changes to psychiatric services (Commonwealth Department of Health and Aged Care, 1998; Commonwealth of Australia, 1995). They have resulted in the deinstitutionalisation and mainstreaming of public mental health services in general hospitals. Other services have been relocated to community support teams, such as community assessment teams (CATs) and mobile support teams (Victorian Government Department of Health and Community Services, 1995; Victoria's Mental Health Department of Human Services, 1994; Victoria's Mental Health Service, 1996b). This has meant that public mental health services are limited to people with a 'serious mental illness' (Victoria's Mental Health Service, 1994). The 1994 policy document Victoria's Framework for Service Delivery (Victoria's Mental Health Service, 1994: 16) warned 'a loss of this focus would quickly result in service capacity being swamped' and 'a consequential inability to respond to those most in need'.

To accommodate terminology consistent with the mainstreaming of psychiatric service delivery, changes in mental health legislation were also initiated. This process of amendment was initiated across the nation in alignment with The United Nations Resolution (United Nations General Assembly, 1991: 5), though not without problems (Commonwealth Department of Health and Aged Care, 1996: 5; Delaney, 1992). The 1995 amendments to the Mental Health Act 1986 (Victoria, 1998) removed the voluntary admission category of admission and detention in an approved mental health service, in line with policy directives (Victorian Government Department of Health and Community Services, 1996; Victoria's Mental Health Service, 1994).

Since that time, involuntary inpatient services have only been provided in accordance with the Mental Health Act 1986 (Victoria, 1998: 17) on the basis that: 'The person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person's freedom of decision and action'. This was an attempt to reduce the number of incidents of human rights abuses to which the United Nations declaration had responded (United Nations General Assembly, 1991). However, the Burdekin report (Human Rights and Equal Opportunity Commission, 1993; Human Rights and Equal Opportunity Commission, 1995) identified that this aim was not in fact achieved and introduced its own problems.

The changes were implemented in a climate of economic rationalism. These economically driven policies have meant a change in policy over whose views define quality service. This shift, it is claimed, has the potential to locate those who receive services to be central to mental health services (Victoria's Mental Health Service, 1996b). In the past service providers were the sole evaluators of quality, whereas now the views of recipients of mental health services, referred to in policy literature as ‘consumers’, are said to be accepted as: ‘an accurate reflection of the experience of receiving services’ (Victoria’s Mental Health Service, 1996a: 1). Though at present the mental health system is still purchaser/provider-driven, the intent was to shift from provider to ‘consumer’ orientated services (Victoria’s Mental Health Service, 1996b).

Professional stakeholders, however, have contested this move. Service providers claim to be fearful that policies that seem to be in the interests of patients are actually working against them as funding is cut and even basic services reduced (Eisenberg, 1995). Even so, providers of mental health services find the use of the term ‘consumer’ for mental health patients inappropriate. Admission to an acute psychiatric facility and a diagnosis of ‘mental illness’, is associated with a question over the competency of the patient as a person and hence denial of legal, civil and ethical rights. This raises the question of who is the ‘consumer’. Ex-patient’s use of the term ‘survivor’ is also experienced as offensive by clinicians, not wanting to consider their services as having been ‘survived’. Nonetheless, an increasingly powerful new social movement in mental health, advocating for patient’s rights, is demanding patients gain recognition as legal, civil and ethical subjects. This movement will henceforth be referred to as the ‘consumer/survivor’ movement.

Consistent with the organisational style of economic rationalism, clinical autonomy in mental health services has been replaced with cost effectiveness (Sachdev, 1996) such that the role of the psychiatrist is reallocated to that of administrator and manager of risk (Rose, 1988). Subsequently, service providers are being held responsible for ‘risk management’ of people with ‘mental illness’ while increasingly being divorced from ‘face to face’ contact with ‘consumers’ of acute public mental health services (Castel, 1991). Despite this shift, the Federal government cites Victoria as a successful example of the relocation of services (Commonwealth Department of Health and Aged Care, 1998).

In the National Mental Health Report (Commonwealth Department of Health and Aged Care, 1998: 56), Victoria was cited as providing twenty-nine percent less inpatient beds than the national average, and ranked the second lowest in the development of mechanisms for consumer and carer participation. Average length of stay was reduced to fourteen days for the 1996-97 financial year; at the same time fifty-two and a half percent of all public admissions were involuntary (Commonwealth Department of Health and Aged Care, 1998: 56-63). These changes have been problematic for the users of public mental health services in a number of ways.

In Victoria, the changes have meant increased difficulty in accessing mental health services. Currently, admission to a mental health service is via assessment by a crisis assessment team, which assesses emergency situations. In 1996 and 1997, sixty-seven percent of admissions to the northern, north east and inner south eastern regions were via crisis assessment teams (Victoria's Mental Health Services, 1996; Victoria's Mental Health Services, 1997). The recipients of these services question the effectiveness of these policies.

One of the measures of effectiveness of psychiatric treatment is relapse or readmission rates (World Health Organisation, 1991: 39). A United States study identified the worst 'recidivists' across one hundred and ninety-six state hospitals had an average of thirty-one readmissions in a year (Geller, 1992). However, the readmission rates in Victoria are only noted within twenty-eight days of discharge. This gives an inadequate indication of 'effectiveness'. The People Living with Psychotic Illness: An Australian Study 1997-98 (Jablensky et al., 1999a; Jablensky et al., 1999b) recorded readmission rates over a year. Significantly, nearly one quarter (twenty-four percent) of those admitted in that study were readmissions in the same year. Yet this kind of information is not attended to. This failure perpetuates problems, as issues are not identified, much less addressed. These problems are also experienced elsewhere.

Chris Burford (2000), a psychiatrist in the United Kingdom, states 'this failure to properly monitor creates a perverse incentive to leave vulnerable people with inadequate support, and perpetuates the revolving door'. In Victoria, for instance, statistics have not been available since 1997 on the current public or community mental health services, the focus having changed to expenditure by the public sector. This is despite claims by the National Mental Health Strategy to greater accuracy in the reporting of mental health services (Commonwealth Department of Health and Aged Care, 1998: 6).

As stated, the current admission criterion focuses on the assessment of risk factors. This means that information available through the power of the Mental Health Act 1986 (Victoria, 1998) is not used to find out what goes wrong, but to continue to deprive people of liberties. In contrast, Chris Burford claims the British Mental Health Act and statutory bodies such as the Mental Health Review Board should be used to identify system failures and facilitate reviews of procedures under clinical governance. He states:

Every readmission should be regarded as a treatment failure and the Mental Health Act Commission should be enquiring how the Trust ensures these are reviewed under clinical governance (Burford, 2000).

The two points in the Mental Health Act 1986 (Victoria, 1998) for which the chief psychiatrist is responsible to intervene in service provision are:

> a) that a person with a mental disorder is not being provided, or was not provided with proper medical care by the service; or

> b) that the welfare of a person with a mental disorder is being, or has been endangered by the service (Victoria, 1998: 131).

These are the two claims that the new social movement in mental health, the consumer/survivor movement reports; yet they remain largely unacknowledged in mental health services.

Rather than attempt to address these problems in mental health services, an attempt to reduce the readmission rates has been made through the introduction of community treatment orders in Victoria, other Australian states and internationally. The British government has followed Australia's example, despite resistance from consumers, survivors and clinicians alike (Mullen, 1996). However, the effectiveness of these orders is yet to be analysed (McDonnell & Bartholomew, 1997; McIvor, 1998). The failure to comply with community treatment orders results in hospital readmission, resulting in skepticism over the effectiveness of these orders to reduce readmission rates. Rather than respond to people's needs, community treatment orders detain people as involuntary patients in the community nd deny people's liberties whilst maintaining them on drug regimes with little other support. 1

The problem with deinstitutionalisation Samson (1995: 67) argues, is that the relocation of involuntary patients to the community has 'not been accompanied with shifts in thinking in psychiatry about mental illness from hereditarian to environmental terms but an expansion of mechanisms of social control into the social domain'. A further implication of this failure is the absence of much needed support services. The previously mentioned report, People Living with Psychotic Illness: An Australian Study 1997-98

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[1] The Mental Health Review Board (1999) has identified a twenty-three (22.9) percent increase in the removal of liberties over the previous two years. Nearly all (98 percent) of the cases heard had clinical diagnoses of psychosis. Involuntary inpatients constituted twenty-eight and a half (28.5) percent of the cases heard and another twenty percent were (involuntary inpatients) on community treatment orders. Even though the number of inpatient hearings fell by five percent due to discharge before the hearing date, the number of community treatment orders hearings increased by twenty percent. Only six (6.4) percent of cases resulted in a discharge of persons from involuntary status.

(Jablensky et al., 1999a; Jablensky et al., 1999b) found mental health services were found to be limited to crisis and emergency mental health services with a lack of adequate community support services. The greatest perceived unmet need was for mental health services (25.6 percent), access to services and treatment (12.6 percent) and continuity of care (9.6 percent). The study found that Victoria had the highest rates of those with psychosis experiencing marginalisation and homelessness (1.3 per 1000 compared to 0.3 per 1000) across the nation. Despite government pledges of improving conditions in the quality of mental health service, deinstitutionalisation has resulted in a crisis in mental health service delivery for governments' worldwide. [2] The resultant increased rates of homelessness, drug use and

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[2] The World Health Organisation's *World Development Report* (Murray & Lopez, 1996) predicts that in 2020 depression will be the leading cause of morbidity. *The Global Burden of Disease* (Department of Human Services, 1999) study has been adapted for use in Victoria and nationally. This study identified mental disorders as the leading cause of disability, and as accounting for twenty-six percent of morbidity, depression being the leading cause of the burden of disease in men and women. Depression is also the single largest cause of disability and mental illness accounts for eight of the top twenty leading causes of health problems in men and seven in women (Department of Human Services, 1999).

related problems in Australia and elsewhere (Jablensky et al., 1999a; Jablensky et al., 1999b), is then perceived as a threat to security. The State response notably in the United Kingdom and Australia, is to re-emphasize institutional care and public safety (Morrall & Hazelton, 2000). The need to protect the public is achieved through forcibly removing 'dangerous' people from the community through acute psychiatric hospitalisation (Morrall & Hazelton, 2000).

Acute psychiatric hospitalisation has become what Hazelton (1999) calls 'the new psychiatric institutionalism', an indication of 'the restoration of asylumdom in mental health care' (Morrall & Hazelton, 2000: 89). The pressurised situation has heightened the crisis over conditions in the delivery of services. The reduction in bed numbers has raised the threshold for admission, and increased rates of compulsory admission, while high bed occupancy has compromised quality of care (Commonwealth Department of Health and Aged Care, 2000; Evaluation Steering Committee, 1997). The conditions have meant reduced staff time with patients and a non

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therapeutic environment with problems of violence, sexual harassment, and drug and alcohol use (Quirk & Lelliot, 2001).

In spite of the recent deinstitutionalisation and the development of a policy of 'community care', the hospital remains the site of mental health services (Morrall & Hazelton, 2000). The key to this analysis is that the changes wrought by the First National Mental Health Strategy have not addressed the most important factor according to acute public mental health service users: dissatisfaction with the service itself. On the contrary, the recent policy changes has placed the quality of care in acute psychiatric services under further threat as demonstrated with increased compulsory admissions, admission rates, bed occupancy rates and a higher proportion of 'difficult patients'.

There is growing evidence of dissatisfaction with service provision across the sector by providers and users alike, with poor staff morale and high staff turnover (McKay & Associates, 1996). Though professional relationships are considered an important aspect of care, due to reduced funds and nurse patient ratios, patient contact has declined. Patients are critical of conditions on the ward as boring and unsafe due to violence, sexual harassment and substance misuse (Graham, 1994; Quirk & Lelliot, 2001).

Barbara Tooth (Tooth, Kalyanansundaram & Glover, 1997: 49) at the Centre for Mental Health Nursing Research at the Queensland University of

Technology found that sixty-one percent of patients found their interaction with health professionals damaging, that is: ‘not only negative but detrimental to their recovery’. These kinds of claims, discussed further throughout the thesis, bring into question the Strategy’s aim to ensure the recognition of consumer evaluation of public mental health services as essential to ensure accountability and quality standards for delivery (Victoria’s Mental Health Service, 1994; 1996a: 1).

Further evidence of dissatisfaction is in satisfaction surveys. A recent survey, Consumer and Carer Satisfaction with Public Mental Health Services Summary Report (Quadrant Research Services, 1997) found that in the metropolitan areas of Victoria only fifty percent of inpatients were satisfied that their rights were being respected. In the metropolitan areas of Melbourne, only forty-two percent were satisfied with information received. The overall level of satisfaction in the 1998 results had only very slightly improved compared with the 1997 results (from 65.85 percent to 67.13 percent) (Nielson, 1998). These poor levels of satisfaction were despite the methodological bias against hearing dissatisfaction in these surveys as Draper and Hill (1996) and others (Carr-Hill, 1992; Westbrook, 1993) have identified.

Further evidence of the consumer experience of damage from the service is indicated in the levels of post-traumatic stress experienced as a result of treatment (McGorry et al., 1991). The Burdekin report (Human Rights and Equal Opportunity Commission, 1993; 1995) also identified ongoing and problematic issues in relation to recent changes in mental health. There is also growing evidence of an increase in suicide rates after contact with mental health services internationally (Appleby et al., 1999; Whiteford, 2000). The law literature (Hoge et al., 1997; 1998; Lidz et al., 1995) also makes it clear that the coercive methods used to fulfil the responsibility of a duty of care to patients generally works against the interests of those it claims to serve.

A recent study: Attitudes of Health Professionals Project: A Best Practice and Literature Review (Commonwealth Department of Health and Family Services, 1998), has also identified that consumers experience more discrimination and stigma from professionals than from anywhere else. This attitude then sets the tone for the rest of society. The recent Evaluation of the National Mental Health Strategy: Final Report (Evaluation Steering Committee, 1997: 12) has stated: ‘consumers reported that providers do not relate to them with an emphasis on dignity, respect and privacy’. And concluded that:

> Mental health care in Australia is a considerable distance from meeting the principles espoused in the Australian Ministers Mental Health Statement of Rights and Responsibilities (Evaluation Steering Committee, 1997: 13).

The two significant areas of concern to consumers in public mental health services were identified as access to treatment and stigma and discrimination experienced in mental health services. As a result of these ongoing problems, the difficulties facing mental health services were considered to be:

> Considerable confusion about the values, attitudes and skills required to work in mental health, and the extent to which consumers can influence these (Evaluation Steering Committee, 1997: 27).

In response to consumer problems in the receipt of services the Report also recommended that:

> The mental health industry needs to define the core competencies required, particularly staff values and attitudes and to develop these in collaboration with consumers and carers (Evaluation Steering Committee, 1997: 27).

The report identified that little training or planning had been invested in new models of care for the mental health workforce. It goes on to say that for core competencies to be developed in consumer/ survivor terms, a new direction is necessary: 'The focus of the new strategy needs to move from the current emphasis on service inputs and structure to service standards, quality and outcomes' (Evaluation Steering Committee, 1997: 26).

In response to these issues, the Second National Mental Health Plan (1998-2003) replaces the First National Mental Health Strategy with a focus on: promotion and prevention, improved responsiveness to the needs of 'consumers' and improved clinical outcomes, quality of life and consumer satisfaction. However, the consumer/survivor perspective, it will be argued here, offers its own definition of quality and service. The question then becomes whether these competencies will be implemented and evaluated in consumer/survivor defined terms.

The recent Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998-2003 (Department of Health and Aged Care, 1999) leaves out of the plan any reference to consumer knowledge in defining quality services. This leaves the definition of quality services in the hands of professionals, a contradiction of its own claims to partnerships with consumers in service provision in an attempt to improve the quality and effectiveness of mental health services.

The Second National Mental Health Strategy continues to rely exclusively on clinical concepts, even while claiming to introduce a new direction. For instance, the introduction of 'outcome measures' was accompanied by the claim of a new direction in mental health for monitoring standards of care. But 'consumer outcome measures' are not subjective measures representing the interests of consumers but a clinical tool of interest to professionals (Andrews, Peters & Teeson, 1994; Stedman, Yellowlees, Mellsop, Clarke & Drake, 1997). And though the value of these instruments in predicting length of stay has been unsupported (Goldney, Fisher & Walmsley, 1998), they have still been instituted across the State of Victoria and elsewhere. Measures such as that recommended by the World Health Organisation (Szabo, 1996; The World Health Organisation, 1998) and of relevance to consumer/survivor issues, have not been implemented. Neither are the current measures of patient satisfaction adequate to represent the interests of consumer/survivors (Allen, Oberlin, Taylor & Zajdel, 1999; Draper & Hill, 1996).

Despite the claims in national policy to improve responsiveness to the needs of consumers and consumer satisfaction, this has not occurred. It is claimed here that improvement would require investigation into the conflict between consumers and professionals. Attempting this research without understanding the different perspectives and conflicting interests involved would be naive. That is, it is not possible to address consumer interests from a professional point of view, as they are fundamentally different points of view. What is needed is an enquiry into what consumers find untenable in acute public mental health services and to inquire into what would be required to transform them. These questions have not been taken seriously in psychiatry because the consumer/survivor perspective has not been considered as legitimate. This thesis is an attempt to do so.

Aim of the Thesis

This thesis is an attempt to identify what concepts are needed to enable mental health services to better meet the needs of people in receipt of mental health services and to identify the practical, ethical and legal implications of any such conceptual shift. That is, what concepts would facilitate providing services that service users would experience as appropriate in psychiatric services? These questions are not to make light of the very great difficulties in the area of treatment of acute psychiatric patients but rather to recognise that even though biomedicine marginalises questions that raises moral, ethical or human rights considerations, these important questions demand attention. Quirk (2001) notes that:

> Very little ethnographic research has been conducted on acute wards in the UK (and none since the 1970s) leaving us with a 'black box' view of inpatient care in this setting (Quirk & Lelliot, 2001: 1565).

Research amongst users is very difficult in the area of acute public mental health services because of the difficulties of eliciting true informed consent. So information will be drawn from other sources. Draper and Hill (1996) suggest the best way to get information is from research users themselves have conducted. So to consider the consumer/survivor experience of acute psychiatric services, a range of local and international consumer/survivor generated literature will be considered.

The consumer/survivor movement emerged as a new social movement internationally 30 years ago (Support Coalition International, 2000; US Department of Health and Human Services, 2001). The movement refers to a large and divergent group with a range of perspectives represented in the debates about the use of terms typical of new social movements explored in the first chapter. From the consumer/survivor perspective, continuing dissatisfaction with services is of great concern. Rogers and Pilgrim (1991a) Pulling Down Churches: Accounting for the British Mental Health Users' Movement argue that because such patients use psychiatric services much more extensively than general health service users, psychiatric user's views are more important than general health users.

The extensive use of psychiatric services, as consumer/survivors themselves highlight (Epstein & Shaw, 1997; Wadsworth & Epstein, 1996a), have long term implications, especially for patients in acute psychiatric wards, as they are already very vulnerable and at risk of further damage. 'Consumers identified acute practices as where the most painful and deeply traumatic things can happen for them' (Wadsworth & Epstein, 1996a: 10). So acute public psychiatric services are the focus of this analysis.

Structure of Thesis

This thesis considers the consumer/survivor movement as a new social movement. These movements are characterised by conflict over identity. The consumer movement will be analysed in the first chapter as a new social movement according to the work of theorist Alaine Touraine. Touraine (1974; 1977; 1978) suggests analysis of new social movements require analysis of the central principal, context and conflict of a movement. He also suggests analysis proceed at two levels: the social events and the social relationships underlying these. The matrix of different aspects and levels of analysis will be addressed in the following chapters. The purpose of considering the consumer/survivor movement as a new social movement is to identify the issues new social movements recognises as central: the moral and ethical issues and their implications for practice. In the arena of psychiatry, this then offers new questions and new ways of understanding and addressing the problems of service delivery in public mental health facilities.

Even though consumer/survivors recognise that there is resistance to their opinions, what they desire most is a change in the culture of service delivery (Wadsworth & Epstein, 1996b). The issue identified as central to the conflict over service provision in the consumer movement literature is the way the patients are treated. This issue then begs the question of how the person in receipt of mental health services is conceptualised. This is taken up as the central question of the thesis.

To address this question of the conceptualisation of the subject in mental health, each chapter explores a different perspective at work in mental health. These different perspectives are associated with and explain the use of different terms in each chapter to refer to the person (subject) in receipt of public mental health services. Chapters two to five raises the question of the conceptualisation of the person in receipt of acute public mental health services in terms of theory, practice, the law and policy in mental health respectively.

The question of the conceptualisation of the subject in mental health is not raised directly in psychiatry. Social theorists argue that it is theory that informs practice, so the theory that informs the current practice of psychiatry in acute public mental health services is considered in chapters two and three by reference to psychiatric texts and psychiatric journals (Fulford, 1994; Fulford, 1996; Ingleby, 1981; Radden, 1996; Rose, 1988; Sadler, Wiggins & Schwartz, 1994; Snaith, 1991). Chapter two identifies is the reliance on biological concepts to explain the presentation of acute mental health problems such as psychosis. It then goes on to consider the work and influence of psychiatrist and philosopher Jaspers (1963), who recognised methodology as centrally important to the development of knowledge. The implication of the reliance on biological is that providers of public mental health services tend to conceptualise acute psychiatric patients as ‘mentally ill’ or ‘sick’ and ‘different from’ or ‘other than’ professionals themselves. As a result, the status of the patient as a person is brought into question.

The second part of this analysis, in chapter three, examines the implications of the concepts utilised in psychiatry for the way a patient is treated in a dual sense. An analysis of limitations of the rationality offered in the diagnostic categorisation highlights the limitations of the explanatory rationale. Its implications for institutional treatment of mental health patients is examined in detail with sections on the work of Foucault and Goffman.

The juridification of the subject is considered in chapter four. The conception of the subject as ‘mentally ill’ is identified as the means whereby coercive practices are authorised in acute mental health services which are supported in mental health law. The Mental Health Act 1986 (Victoria, 1998) authorises the use of ‘reasonable force’ to admit patients against their will and thus protects those who deliver coercive practices. This ‘treatment’ includes involuntary admission, detainment, isolation, physical restraint, drug and electroconvulsive treatment of patients. Psychiatrists are the personnel authorised to administer, diagnose, detain and treat people.

The result is that these coercive treatments contribute further damage to an already traumatised sense of self. It is argued in chapter five that the negative implications of these practices on the lives of those subjected to involuntary treatment are the responsibility of the authorising body: that is, the State. However, the information used to evaluate public mental health services is highly selective. For instance, indications of inpatient trauma are not recognised as such but considered further evidence of patient pathology. This chapter attempts to consider the broader issues of social, legal, medical, practical and institutional context of policy development in the light of the current construct of risk management and its implications for public mental health patients.

The next section of the thesis is an attempt to explore how to improve services in response to the issue consumer/survivors have raised. Chapter six enquires into how the philosophical debates within psychiatry around the conception of the subject have been addressed in the work of R.D. Laing (1965a; 1965b; 1966; 1971b; 1985). Laing offered an alternative or counter paradigm for understanding psychiatric problems, which also offers an understanding approach to psychiatric patients. Chapter seven goes on to considers how Laing's understanding approach might be utilised in responding to people in acute psychiatric services, in a way that accommodates the demands of the consumer/survivor perspective.

For this to occur, what is required is considering patients as legitimate subjects in a way that transforms the intersubjective practice of psychiatry, so that the problems identified by consumer/survivors can be addressed. Of particular relevance here is the conceptualisation of the subject as an interpretative subject in the work of philosopher Charles Taylor (1985b; 1985c; 1989). This conceptualisation is taken further and operationalised into a simple though complex matrix and workable approach of narrative in the work of Paul Ricoeur (1981a; 1981b; 1981c; 1992). What is identified is the important role of narrative in the construction of identity. The basic requirement for this ethical practice is listening in a face-to-face relationship, as expressed in the work of Emmanuel Levinas (1981; 1998a; 1998c).

Chapter eight is a discussion of the implications for practice of the claims of the consumer/survivor movement as a new social movement. The failure to involve consumers in the creation and design and evaluation of services leaves consumers as patients in a passive state. There is no recognition of the value of consumers' contributions in their own right. The failure to listen to patients in acute psychiatric services is a failure to recognise people in receipt of acute psychiatric services as subjects. This failure is institutionalised through the failure to organise acute psychiatric services around interpersonal relationships between subjects based on dialogue and communication. Government and consumer/survivor incentives to reverse this failure and their limitations are considered.

The key premise of this chapter is that as established in chapter one, the barrier to participation for consumer/survivors is discrimination and stigma. Stigma denies the recognition of the value of the patient as a person and the value of consumer/survivor perspective and knowledge as legitimate. Overcoming stigma, it is claimed in chapter eight, is through recognition of the unique value and worth of each patient as a person. The absolute basic necessity of recognition of the subject as an equal ethical, legal and social subject is considered through the work of Alex Honneth's (1995) The Struggle for Recognition: The Moral Grammar of Social Conflicts. This concept calls into question the current ethos of acute psychiatric services. It highlights the ethical necessity of the need for the patient to be recognised as a subject.

In sum, the topic of the thesis can be put in a number of rhetorical questions. Does the concept of the patient as an ethical subject, embedded in a narrative, (as explored in chapter seven) provide an adequate methodology to meet the practical and ethical demands of the consumer/survivor movement? Does it address and articulate the interests and concerns of consumer/survivors? What else is needed? What community values and practices are needed to facilitate and support this ethic of practice? These questions necessarily raise questions of a broader social context. What community values are required to support and provide a framework whereby those who most rely on those services can be the designers of those services? Consideration is given to consumer/survivor designer methodologies that utilise a consumer/survivor perspective ethic, and henceforth challenge and revolutionise the current paradigms of treatment. The central question of the thesis is: what does it take to recognise the patient as a subject in acute public mental health services?