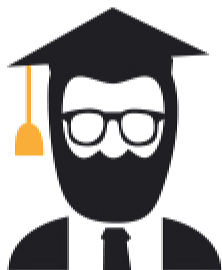
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Madness versus badness: the ethical tension between the recovery movement and forensic psychiatry

Claire L. Pouncey · Jonathan M. Lukens

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Abstract The mental health recovery movement promotes patient self-determination and opposes coercive psychiatric treatment. While it has made great strides towards these ends, its rhetoric impairs its political efficacy. We illustrate how psychiatry can share recovery values and yet appear to violate them. In certain criminal proceedings, for example, forensic psychiatrists routinely argue that persons with mental illness who have committed crimes are not full moral agents. Such arguments align with the recovery movement's aim of providing appropriate treatment and services for people with severe mental illness, but contradict its fundamental principle of self-determination. We suggest that this contradiction should be addressed with some urgency, and we recommend a multidisciplinary collaborative effort involving ethics, law, psychiatry, and social policy to address this and other ethical questions that arise as the United States strives to implement recovery-oriented programs.

Keywords Recovery movement · Bioethics · Psychiatry · Social policy · Moral agency

Introduction

With its consistent message that persons with severe mental illness can and should be responsible for their own life choices, the recovery movement in the United

C. L. Pouncey (✉)
Center for Bioethics, University of Pennsylvania, 3401 Market Street, Suite 320, Philadelphia, PA 19104-3308, USA
e-mail: pouncey@mail.med.upenn.edu

J. M. Lukens
School of Social Policy and Practice, Center for Bioethics, University of Pennsylvania, 3701 Locust Walk, Philadelphia, PA 19104-6214, USA

States has made progress in overcoming the stigma of mental illness, advancing the civil rights of persons with severe mental illness, and providing better and more accessible treatment for mental illness. However, in deliberately emphasizing the capabilities of persons with mental illness for self-determination, recovery advocates leave unaddressed important questions about how, when, and to what extent mental illness can limit a person's capacity to make sound choices, or even her moral accountability. Although both psychiatry and medical ethics share the ideals of the recovery movement, these disciplines recognize that severe mental illness can limit agency. In relation to forensic psychiatry in particular, this creates an uncomfortable tension because the recovery movement has not explored how its principles can extend from civil matters to criminal law. The recovery movement's silence on the limits of moral agency in persons with severe mental illness creates an ethical disconnect between forensic psychiatry, medical ethics, and recovery principles. This discussion will argue for the importance of combined efforts from these three disciplines to address problems of agency in severe mental illness. We will show that the three approaches to understanding moral agency in persons with severe mental illness are not inherently antithetical but do need to better inform one another.

The recovery movement

Beginning in the 1950s, mental health policy in the United States changed dramatically, as new psychiatric medications became available, the civil rights and rehabilitation movements gained momentum, and the government made funding available for community-based treatment of persons with mental illness. In this time of political, social, medical, and economic flux, there was a strong trend toward deinstitutionalizing persons with severe mental illness and providing adequate community based treatment for them. Throughout the 1960s and into the 1970s, new federal funding led to the establishment and expansion of community mental health centers throughout the United States [1–3]. However, policy reformers paid insufficient attention to the challenges many formerly institutionalized persons faced in the community, especially in terms of finding appropriate housing, work opportunities, outpatient treatment, and community acceptance [4], and many persons who had spent years in institutions failed to thrive in the community setting. In addition, mental illness carried a great deal of social stigma, creating overwhelming barriers to full social integration.

The psychiatric rehabilitation movement emerged in this setting as an effort to expand the limited scope of mental health treatment by arguing that effective, comprehensive treatment of mental illness must address psychosocial as well as psychiatric needs. In order to meet the full range of psychosocial needs of persons with severe mental illness, psychiatric rehabilitation emphasized illness management and community reintegration, along with psychiatric treatment. It focused on developing mechanisms for social intervention, such as interpersonal skills, access to social services and resources, and improved practical and legal mechanisms for maximizing patient self-determination. This movement empowered persons with

severe mental illness to collaborate with community care providers to plan their own treatment, and the focus changed from the passive treatment of medical deficits to the development of personal strengths [5].

Whereas the psychiatric rehabilitation movement arose as an effort among care providers and policy makers to improve community services, the mental health consumers' movement began as a self-help initiative among persons who were being transitioned from institutional to community-based care by creating self-help groups and peer-managed programming for persons with mental illness [6]. The consumers' movement advocated not just effective treatment and resources, but also basic human rights. It strived to empower persons with mental illness with lexical changes, making them active "consumers" of mental health services, rather than passive psychiatric "patients." It fought against social discrimination and stigma by emphasizing the capabilities of mental health service consumers rather than their disabilities. In doing so, the consumers' lobby became a strong voice for mental health advocacy, conveying to both consumers and the public that how we provide care is as important as what care we provide.

The psychiatric rehabilitation movement and the mental health consumers' movement thus laid the foundation for the modern recovery movement, which merges the multifaceted psychosocial treatment approach of the psychiatric rehabilitation program with the consumer-focused civil rights agenda of the consumers' movement. However, the concept of "recovery" has been defined in myriad ways, and those definitions have shifted over time, which has led to an inherent ambiguity in the movement and resistance from organizations that do not fully understand the movement's mission.

Note that the recovery movement is *not* an updated version of the anti-psychiatry movements of the 1960s and 1970s. Although psychiatry still has critics who question whether mental illness exists or whether psychiatry has any real treatments to offer, the recovery movement does not conceptually preclude or practically exclude psychiatry. Recovery advocates share the belief that mental illness exists, and that it can impair rational processes. It departs from the psychiatric tradition in that the recovery movement circumscribes psychiatry's role to one of many possible means to improve the quality of life for persons with severe mental illness. It advocates that persons with mental illness are persons, full moral and political agents, and the movement discourages both consumers and health care professionals from seeing persons with mental illness as mere embodiments of a diagnosis or a collection of symptoms. In other words, the recovery movement does not disparage psychiatry as merely assigning empty diagnostic labels, but it views persons as more than their diagnoses, and it sees psychiatry as one of many methods to instill in consumers a full sense of agency and social participation.

Although mental health policy in the United States has rallied around the recovery movement, the "recovery" concept is difficult to characterize consistently or define clearly. The *National Consensus Statement on Mental Health Recovery* lists ten "fundamental components" that would make a mental health program recovery-based: self-determination, person-centered care, empowerment (including the protection of civil rights), holism, nonlinearity, respect, focus on strengths rather than weaknesses, peer support, responsibility, and hope [7]. Davidson et al. note the

imprecision and inconsistency with which both the term "recovery" and these specific goals can be interpreted [8, 9]. They endorse an understanding of recovery with respect to mental health as "recovery in" rather than "recovery from" serious mental illness, thus distinguishing mental health recovery from curing mental illness. Rather than attempting to eliminate psychiatric symptoms or illness, recovery "calls for the provision of accommodations and supports that enable people with psychiatric disabilities to lead safe, dignified, and full lives in the community" [8].

Jacobson and Greenley distinguish between "internal and external conditions [that] produce the process called recovery" [10]. Internal conditions are those within the individual, many of which were advocated by the consumer movement: hope, healing, empowerment, and connection. *Hope* is the belief that recovery from severe mental illness is possible; *healing* is the process of controlling symptoms and refusing to see them as defining features of oneself; *Empowerment* entails assuming a greater role in ones treatment; and *connection* entails finding "roles to play in the world."

External conditions are the components of a supportive sociopolitical environment that includes respect for human rights, a "positive culture of healing," and recovery-oriented services, echoing the agendas of both the psychosocial rehabilitation and the consumer movements. *Human rights* entail an equitable distribution of power between consumers and providers, as well as the satisfaction of basic needs from goods that range from food and shelter to healthcare parity. A *positive culture of healing* is one that allows social inclusion and the amelioration of stigma for persons with severe mental illness. *Recovery-oriented services* are those that integrate treatments provided by both health care professionals and consumer peers.

Others view recovery as "an ongoing, dynamic, interactional process that occurs between a person's strengths, vulnerabilities, resources, and the environment" [11]. It is client-centered, in that the consumer decides how her recovery goals, as well as her success in reaching them, ought to be defined. It consists in an approach to treatment in which service consumers and service providers collaborate. Anthony defines recovery as the "development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability"; he communicates the importance of reconceptualizing one's life to accept the presence of persistent mental illness, while also expecting a rich, rewarding, and meaningful life [12].

We find that recovery is best understood not as an intervention or endpoint, but rather as a set of values and aims that constitute a treatment ideology. As such, we believe that the term "recovery" delivers an important, influential, but often rhetorical message that advocates will need to refine in order for the ideals to be implemented.

Community psychiatry and civil commitment

Psychiatry generally shares the recovery movement's ideals, but comes to them from a different direction. In particular, community psychiatry—the psychiatric

subspecialty that works most closely with the population of severely mentally ill persons—has in large part embraced the concept of recovery. However, psychiatry was not part of the original psychiatric rehabilitation or consumer self-help movements from which the recovery movement grew, and so psychiatrists tend to be less familiar with the term "recovery" or the concepts used to describe the basic principles (e.g., "consumer-oriented") [13]. Psychiatry is not antithetical to recovery, but there is a great deal of misunderstanding on both sides that impede communication and collaboration.

Both recovery advocates and psychiatrists believe that mental illness exists, and that it can interfere with a person's rational capacities and abilities to make sound decisions that promote his own best interests. Although psychiatry has been accused of defending an inappropriate "medical model" of mental illness that posits a reductionist and oversimplified view of mental illness, most of psychiatry, instead, embraces a biopsychosocial model, which acknowledges bidirectional causal influence among persons, their environments, and their psychological and biological constitutions [14]. Furthermore, psychiatry distinguishes different kinds and degrees of mental illness, thus recognizing that even patients with similar diagnoses, symptoms, and life events cannot be treated identically. Finally, psychiatry recognizes that most mental illnesses have symptoms that wax and wane over a person's lifetime, so that previously debilitating symptoms may remit, or a person who is functioning well overall may relapse through no fault of his own. Psychiatry thus shares the view of recovery advocates that people do develop mental illnesses (i.e., as opposed to mere "problems in living" [15]), but that carrying a certain diagnosis does not permit assumptions or predictions about a person's ability to function in the world.

Psychiatry is the only medical profession represented among the behavioral health professions and is the perpetrator of some of the institutional abuses against which the community mental health, psychosocial rehabilitation, consumer self-help, and recovery movements have reacted so strongly. So some critics of psychiatry might be surprised to learn that psychiatry shares some of the fundamental values of the recovery movement, as reflected in the *Principles of Medical Ethics With Annotations Especially Applicable for Psychiatry*, published by the American Psychiatric Association [16]. These principles are shared in full with other medical disciplines, and there are areas of significant overlap with the ethics codes of other behavioral health professions, as well as with the recovery movement. As does all of medicine in the United States, psychiatry respects patients' abilities and rights to be involved in making their own medical and life decisions—this is the widely embraced ethical principle of patient self-determination. In addition to self-determination, the *Principles of Medical Ethics* require that physicians both lobby for political change and protect patients' civil rights, which also align strongly with recovery values. Psychiatrists endorse these principles as an integral part of professional training, rather than as a response to consumer demand or a particular social reform movement.

However, physicians also are aware that symptomatic patients are not always capable of fully autonomous decision making, often because the problems that bring them to treatment impair cognitive and reasoning processes. Physicians always

ought to maximize patient self-determination, but also must balance it against the simultaneously held values of beneficence and nonmaleficence. That is, doctors must help their patients, or at least refrain from harming them.

However, the subjects of physicians' beneficence can always interpret those actions as paternalistic, coercive, or otherwise harmful. Many of the reforms addressed in the recovery movement can be recast in terms of the rival values of self-determination and beneficence. Before the 1960s, few biological treatments were available for severe mental illness, especially for treating acute psychotic episodes. The days of indefinite hospitalizations in large state institutions were based on the limited psychiatric knowledge of the times, together with a societal belief that providing institutional care was beneficent. This is not to excuse some of the known abuses that took place in psychiatric institutions during the first half of the 20th century; in retrospect, we now know that institutionalized patients suffered many harms, including violation of fundamental liberty rights. Some critics of psychiatry will likely consider this too charitable an interpretation of an unfortunate part of U.S. history. Our aim here is not to excuse offenses, but to illustrate how psychiatrists may have erred on the side of beneficence when they believed severely ill patients had limited capacities for self-determination.

Another principle of medical ethics helps explain some of the tension between psychiatry's persistent use of the term "patient," and the preference of those persons to be called "clients," "consumers," or "stakeholders." Recall that the "consumer/survivor" and psychiatric rehabilitation programs both struggled for persons with psychiatric illness to be thought of as full agents, rather than as the sum of their symptoms. Recall, too, the recovery movement's promulgation of person-centered care. These efforts are meant to re-conceptualize for care providers, as well as for consumers and their families, persons with mental illness as not merely passive recipients of diagnoses and treatments but as full participants in the process of deciding how to live with certain vulnerabilities. Furthermore, referring to oneself as a consumer provides a mechanism for asserting the independence and autonomy that the recovery movement urges others to recognize. Despite these efforts, psychiatrists are the holdouts among behavioral health professionals in using the word "patient" to describe the persons they treat; psychologists and social workers, among others, have adopted the terms "client" or "consumer" to describe those who utilize their services.

Medical professionalism instills in all physicians an obligation to serve the needs of the patient who cannot be abandoned once a doctor-patient relationship has been established. As stated in Section 8 of the *Principles of Medical Ethics*, "A physician shall, while caring for a patient, regard responsibility to the patient as paramount" [16]. Doctors have resisted conceiving of their professional relationships as contracts with clients or as commercial services for sale to consumers, because doing so interferes with the sense of professional responsibility that has been ingrained since early in medical training. Furthermore, it is part of psychiatry's professional identity to maintain its status as a medical discipline: just as other medical specialties continue to treat "patients," so does psychiatry. For psychiatrists to treat "clients" or "consumers" rather than "patients" dilutes their sense of responsibility to persons with mental illness. However, it is easy to see how

psychiatry's critics could interpret this resistance as an attempt by psychiatry to remain politically dominant among the behavioral health professions, especially since the growth of multidisciplinary teams is diffusing the power of the psychiatrist [13].

The responsibility for patients that psychiatry assumes for itself is simultaneously endorsed by the public's reliance on psychiatry to settle certain civil legal issues, most notably, civil commitment. Many of the public battles fought by recovery advocates over the last 60 years concern the extent to which autonomy can be attributed to persons with severe mental illness, the extent to which medication or hospitalization can be imposed against a person's wishes, and the extent to which the powers of the state and the psychiatric profession can be curtailed in order to empower the persons who suffer with mental disabilities. The Supreme Court of the United States has weakened states' abilities to confine people involuntarily and without the provision of treatment. However, psychiatrists still have a legal obligation to involuntarily commit persons who are dangerous as well as suffering from symptoms of a mental illness. Psychiatrists and other behavioral health professionals bear legal responsibility for protecting the public from patients whose mental illnesses make them dangerous by hospitalizing them involuntarily [17, 18]. And psychiatrists must ascribe a diagnosis in order to do so. Psychiatric diagnoses are thus used to justify coercion, and psychiatry is forced into the role of the paternalistic enforcer. This social expectation creates a dual agency for the individual psychiatrist and an uncomfortable tension for the profession, both of which may be misinterpreted as a play for power and a violation of recovery values.

Ironically, patients who are involuntarily committed to hospitals are often those who stand to benefit most from the application of recovery principles. There has been some progress toward implementing systems that maximize patient self-determination even while they experience symptoms, such as instituting outpatient commitment laws and advance directives for mental health care. Such measures are of limited value, since in order to be effective, the patient must still desire treatment during her symptomatic episodes, an assumption that may not hold true. When a person experiences active symptoms that lead her to decline treatment, psychiatrists are less likely to respect patient preferences than they would be in a less critical situation [19]. Although the values that guide the recovery movement and psychiatry align in several central ways, there is reason for consumer criticism about psychiatrists' willingness to act paternalistically, if not coercively. However, it is important to note that such situations arise only when a patient is symptomatic and dangerous, and is refusing the treatment that the psychiatrist *and the state* believe is necessary. Community psychiatry's dual allegiance to the public as well as to the patient occurs by mandate, not by choice.

Apart from civil commitment requirements and psychiatry's insistence on calling the persons who seek their care "patients," the professional values of psychiatry and those of the recovery movement align in several crucial respects. The significant divergences arise from psychiatry's concomitant commitments to other professional values. However, the alignment is further strained in forensic psychiatry in ways that present a real challenge to the recovery movement.

Forensic psychiatry, recovery, and culpability

Forensic psychiatry, another psychiatric subspecialty, shares psychiatry's basic commitments but differs from community psychiatry in ways that are relevant to the recovery movement. Although public concerns sometimes temper the community psychiatrist's moral obligations to a patient, there is still a physician-patient relationship between them. In contrast, forensic psychiatrists sometimes work outside of any such relationship. Rather, forensic psychiatrists often work for the state, providing treatment within prisons or other forensic facilities; or they may be hired by an attorney to provide expert testimony either for or against a person with mental illness at trial. This creates a new set of ethical tensions for the forensic psychiatrist. Since forensic psychiatrists are involved in criminal as well as civil matters, psychiatrists who assess or treat prisoners or detainees do so in an inherently coercive setting in which self-determination is already strongly curtailed. Furthermore, when a psychiatrist testifies for the prosecution in a criminal trial, successful testimony may actually harm the patient, thus apparently violating the medical ethical principles of beneficence and nonmaleficence. In either case, the psychiatrist is not working directly for the patient, and at times may work *against* the mentally ill person, thus precluding a formal doctor-patient relationship.

Forensic psychiatry also contrasts with community psychiatry in that it often uses diagnosis in ways that counteract recovery principles. We saw that civil commitment uses psychiatric diagnosis in part to authorize involuntary commitment; forensic psychiatrists similarly use diagnosis to support recommendations regarding workers' compensation, child custody, or criminal culpability. In such cases, forensic psychiatry provides (a) a person's diagnosis and (b) psychiatric theory about how the symptoms associated with that diagnosis are likely to influence behavior. The state uses the forensic psychiatrist's report to decide whether to restrict the personal freedoms or entitlements in question. Although forensic psychiatrists strive to maintain neutrality and objectivity in making these assessments [20], such practices appear to legitimize the recovery movement's concern that persons with mental illnesses are not recognized as full agents but simply as the sum of their symptoms.

One important role of the forensic psychiatrist is to elucidate any causal role played by mental illness when persons with mental illness commit criminal acts. Sometimes psychiatrists serve as expert witnesses in criminal proceedings to testify whether the offender's mental illness makes her incompetent to stand trial, i.e., to determine whether psychiatric symptoms render that person incapable of understanding the legal proceedings against her or of assisting in her own defense [17]. At other times, forensic psychiatrists are called upon to testify whether mental illness may have caused the criminal behavior in question. In such "insanity defense" cases, courts and juries use psychiatric testimony to decide whether the mental illness mitigates or exonerates the offender's responsibility for the act in question [21]. While the forensic psychiatrist does not ultimately decide the guilt or innocence of the offender, the role of the forensic expert is relevant to the recovery movement because it revives questions about whether and to what extent we can attribute social deviance to mental illness. Despite decades of sociological critique

that psychiatry cannot infer the existence or presence of mental illness from deviant behavior alone [22], the forensic psychiatrist presupposes that severe mental illness can cause not just deviant but criminal behavior. Note that this is not the same as claiming that *all* social deviances are attributable to mental illness, nor that mental illness *always* causes deviant behavior. The lingering question is on what grounds and in what situations a psychiatrist can legitimately infer that mental illness caused a criminally deviant behavior.

The corollary question is at what point society in general and psychiatry in particular are justified in questioning the moral and legal agency of a person whose mental illness severely influences his behavior. This question about agency is an old one in ethics, and it cuts to the heart of the recovery movement's position. As we have seen, the recovery movement's core value is to presume that all persons with mental illness are fully self-determining agents. However, recovery advocates do recognize that even in treatment, people with severe mental illness can expect a recurrence of symptoms at various times throughout their lives, and they are not to be blamed for those recurrences. But the recovery movement remains agnostic about how to reconcile patient autonomy and accountability, leaving policy makers to wonder how we should understand the transient changes to moral and legal agency that severe psychiatric symptoms can cause.

The situation can be characterized in Kantian terms. We can cast the recovery movement's central values as a commitment to both the moral worth of persons with mental illness and to their full participation in a community of moral agents who jointly decide how to conduct themselves in society. How does that community respond when a member violates the moral law? One response is that the person knowingly acted immorally, and should therefore suffer the consequences of doing so. But one also might consider whether the rational capacity a person requires in order to function as a full moral agent was compromised, giving that person's actions a different moral valence. That is, we ascribe culpability to rational moral agents who knowingly violate the moral law, but the misdeed itself can lead us to question whether the person who committed it was rational at the time. When rationality is called into question, a moral transgression might be less blameworthy in the eyes of the community, but the person must relinquish status as a full moral agent. Yet it is just this sense of agency that the recovery movement wants to protect for persons with severe mental illness.

Although the recovery literature encourages mental health care providers to treat persons with mental illness as fully rational agents, it is silent on the question of how to understand immoral and illegal acts committed by those persons when their agency seems to be transiently compromised by mental illness. The *National Consensus Statement on Mental Health Recovery*'s "fundamental components" include both self-direction and responsibility [7], suggesting that both our civil and our criminal social systems should treat persons with severe mental illness as they treat anyone else. However, with respect to criminal behavior, the mutual emphasis on responsibility and self-determination creates a paradox: whereas mental illness can be used to mitigate culpability when it causes illegal behaviors, the recovery movement could be expected to advocate against the position that mental illness exculpates illegal or immoral acts. With respect to socially aberrant or abhorrent

behavior, these fundamental components suggest that the influence of mental illness on behavior should not excuse illicit acts.

Such a conclusion seems to contradict the basic message of the recovery movement, that even with psychiatric vulnerabilities, persons with mental illness have equal moral worth and deserve assistance to function fully in society. Besides access to services, jobs, education, housing, and treatment, this assistance includes a long history of special consideration under the law and efforts to divert mentally ill persons from prisons. The recovery movement now faces a dilemma: how can we advocate treating persons with mental illness as full moral agents for the purpose of providing social goods, while simultaneously treating them as compromised moral agents when the same illness earns them social sanction? Worded differently, if recovery entails reducing the stigma of socially deviant behavior, and discouraging professional and governmental programmatic efforts to coerce conformity, can it consistently reconcile the use of psychiatric symptoms to excuse immoral or illegal acts?

However we phrase it, the question is not rhetorical. In 2003, the ongoing efforts of the recovery movement were rewarded in the United States when the President's New Freedom Commission on Mental Health submitted a report [23] that endorsed recovery values. It does not, however, provide substantive recommendations for how such ideals might be realized. While the New Freedom Commission's report promulgates the assignation of full agency to persons with mental illness, it does not explicitly address the question of *moral* or *legal* agency. Davidson interprets the report as an argument for recovery principles to guide all mental health services, *except* for forensic services for offenders with mental illness, which might strive instead for "containment or community safety" [8, p. 643]. Indeed, the report presupposes that some mental health care will be provided to prisoners, and it calls for providing appropriate diagnosis and treatment for offenders who are in jail. This suggests that having a serious mental illness does not automatically excuse criminal behavior. The report also advises that persons with symptomatic mental illness who have not committed crimes be diverted out of the legal system and provided with treatment in a safer and more appropriate setting. This reinforces the recovery principle that unpredictable behavior caused by severe mental illness is not in itself cause for confinement. However, the report also calls for providing "supervised community care" for "nonviolent offenders" [8, p. 43]. This possibility suggests that nonviolent criminal offenses committed by persons with severe mental illness may be at least partially excused by the illness, or that the illness may mitigate the punishment. The report does not specify *which* symptoms exculpate *which* otherwise unjustified behaviors, nor does it justify modified punishment for offenders with mental illness.

The insanity defense thus raises an important challenge for recovery, even as it seems to legitimize the movement's concerns about the appropriate role of psychiatry in mental health care. Forensic psychiatry provides an opportunity for some offenders to receive treatment rather than punishment, which is consistent with the recovery movement's call to minimize the social mistreatment of persons with mental illness. But it seems to violate the recovery movement's insistence that mentally ill persons are full agents who can "lead, control, exercise choice over, and

determine their own path of recovery" [7] when it uses compromised agency as the basis for mitigating responsibility for social wrongs.

Can bioethics be a resource for the recovery movement?

Describing the tension between the recovery movement and the practices of forensic psychiatry in terms of Kantian agency elucidates both epistemological and ethical aspects of the problem. The epistemological questions concern how we can know about mental illnesses apart from their observable behavioral manifestations, and what counts as evidence for or against that knowledge. These questions have been addressed extensively in the philosophy of psychiatry, and we will not review them here [24–26]. Additionally, some provocative empirical research is being done to identify what personal capacities and abilities are affected in persons with severe mental illnesses [27, 28], as well as how recovery principles might be enacted in forensic psychiatry [29, 30].

The question of agency in severe mental illness is fundamental, but neither the recovery movement nor bioethics has devoted much attention to it, either severally or jointly. We find this inattention surprising. Like the psychiatric rehabilitation and consumer self-help movements, academic bioethics also grew from the civil rights concerns of the 1950s and 1960s. It has been the source of influential discussions of practical questions about patients' rights, self-determination, quality of life, advance directives, substituted judgment, and truth-telling to patients, which are all topics that have been addressed with respect to the recovery movement. Also, like the recovery movement, bioethics has contributed both directly and indirectly to social reforms, some of which have been applied to behavioral health, such as the initiation of advance directives for mental health care. The bioethics literature also includes a charged debate about how to define "mental disorder," and how to understand mental disorders as similar to or different from medical diseases [25, 26, 31, 32]. Most pertinently, central questions about capacity and agency have been addressed in bioethics [33–37]. However, despite the parallel histories and mutual interests, the field of bioethics has not specifically engaged with the recovery movement to address concerns about patients' rights and moral agency, nor has it significantly clarified conceptual issues about self-determination, accountability, and culpability with respect to forensics.

We believe that academic bioethics, law, forensic psychiatry, and recovery-oriented social reformers would do well to collaborate. If social programs for the mentally ill are to be "transformed," as the New Freedom Commission's report suggests they should be, part of that transformation should include opportunities and mechanisms for multidisciplinary collaboration. These could include joint workshops, conferences, and research projects to address both conceptual and practical obstacles to implementing recovery ideals. It is important that scholars, recovery advocates, and public policymakers explore together how our society will address moral agency and legal responsibility among persons with severe mental illness. Although activists may not welcome views from the ivory tower, the recovery movement is likely to benefit from historical perspectives, theoretical arguments, and

conceptual analyses. Forensic psychiatry might be called upon to contribute insights about the heterogeneity among disorders, symptoms, and the persons who exhibit them, in order to avoid overgeneralizations that hinder progress in adopting other recovery values. Ethical and legal scholarship might help to compare legal, moral, and political conceptions of agency. Finally, recovery advocates will keep the interests of stakeholders at the forefront of the exploration while benefiting from expertise about how to execute the particulars of the vision. We believe it will take input from multiple voices to implement recovery ideals without confusion or contradiction.

This joint effort could go onto address further questions that affect the implementation of recovery-based policies, such as, Are all volitional behaviors morally equivalent? Who has responsibility for deciding a person's capacity to do good or to abide by a basic social contract? or What mechanisms exist for transforming systems and educating the public about recovery implementation? Interdisciplinary programs could be developed to educate police, forensic facility staff, courts, and juries. A joint effort may also elucidate how prisoners with mental illness could benefit from recovery principles. Other questions are sure to follow.

Our goal here is not to set an agenda, but to call attention to how values and rhetoric can shape policy only up to a point. We have provided one example of how the current practices of one mental health subspeciality elucidates a contradiction in the basic recovery message. This single paradox posed by the mutually endorsed values of agency and responsibility should alert activists and policymakers that some fundamental problems need to be addressed before the recovery vision can be enacted.

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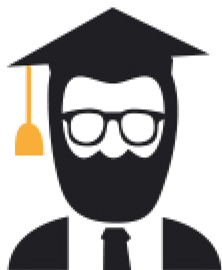

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