



**NZNO Mental Health Nurses Section
Newsletter
December 2022**

So this is Christmas, and what have we done?

What have we done? Let's try to summarise it.

2022 has been an incredibly demanding year for Mental Health Nurses. Just last month, [Newshub](#) told us what we already knew – that despite the ever-increasing demand on services and a \$1.9 billion funding injection in Budget 2019, there are no more acute inpatient beds today than there were when [Labour leader Jacinda Ardern](#) declared a “[mental health crisis](#)” in 2017.

Health Minister Andrew Little [assured the public](#), once again, that new frontline roles in GP surgeries, kaupapa Māori services and specialist youth clinics for those with mild to moderate health needs “meant those getting help would be less likely to need acute services down the track.” Yet the latest [figures from the Mental Health and Wellbeing Commission](#) tell a different story. The number of people needing specialist mental health and addiction services has increased from 176,310 in 2016/17 to 191,053 last year. And wait times – especially for addiction and youth mental health services – are going up, not down.

And to top it all off, in 2022 Mental Health Nurses also managed the effect of the COVID-19 Omicron wave on already unsafe staffing levels, on infection control requirements and on the health needs of the people we care for. And we managed it well.

We deserve recognition. We deserve to be valued. Achieving this is the mission of the NZNO Mental Health Nurses Section. We aim to bring mental health nurses together in their diversity to positively influence policy and practice for the development of consumer centered care in New Zealand/Aotearoa.

In this final issue of the *MHNS Newsletter* for 2022, we introduce our newest Committee member, provide an update on the activities of the Committee on your behalf and look forward to a brighter 2023, when we can gather again in person to promote leadership, education and professional development of mental health nursing in New Zealand/Aotearoa.

We also include our regular feature article. For this issue of the *MHNS Newsletter*, we

have chosen a perspective paper from the *International Journal of Mental Health Nursing*. The author, Professor Marie Crowe RN of the Department of Psychological Medicine at University of Otago, Christchurch, acknowledges that it is a personal viewpoint and readers may not agree with every detail. But we feel that it expresses the values and vision of Mental Health Nursing, which are all too rare in the world today.

We hope you find something of value in the following pages. If so, do feel free to forward it on, and maybe add a suggestion that your NZNO Mental Health Nursing colleagues [join the Section](#) as well.

Introducing new Committee member Fiona McNair



The MHNS Committee continues to rebuild, strengthened by another new committee member who has joined us this year. Fiona McNair, originally from the South Island, now lives in Palmerston North. She is a mother of three adult sons, a grandmother of five grandchildren and an experienced community nurse with varied mental health work history spanning the past 25 years. Fiona worked at the Manawaroa acute inpatient ward originally developed by Sir Mason Durie, then moved to adult community mental health and crisis mental health service on call. For the past 18 years she has been with Palmerston North's Older Adult Mental Health Service in the community team.

Fiona has been involved in a range of projects and committees, including the PDRP advisory group, quality groups and related projects, and has been an NZNO delegate for many years supporting others to resolve issues in the workplace in a range of employment and professional issues.

Although her time is limited due to current work commitments, we are very pleased to welcome her as a co-opted Committee Member for the period up until the next MHNS Biennial General Meeting in March 2023 (see below for more info).

The Committee, which comprises in addition Helen Garrick (Chairperson), Jennie Rae (Treasurer), Brent Doncliff (Secretary) and Grant Brookes (newsletter editor), is still looking for new members to cover current and anticipated vacancies next year. We invite any new, emerging leaders to join us, with a promise that we share the load so that no new Committee Member will be overburdened. To express your interest, please [click here](#) for a nomination form.

Committee news

The MHNS Committee has met twice since our last newsletter in June. At our July meeting, we held discussions with the newly-appointed NZNO CEO, Paul Goulter. We were particularly interested in Mental Health Nursing representation on national meetings that NZNO attends and processes to ensure that MHNS can provide input or direction to those attending. We were also concerned about NZNO's internal Addressing Violence Against Nurses (AVAN) project, which MHNS was part of, going into recess and about the direction of the NZNO Constitutional Review, which MHNS had jointly initiated along with the Cancer Nurses College.

These latter concerns were borne out with the release of the Constitutional Review Report in September, which unfortunately did not meet requirements. MHNS will continue to work for reform of the NZNO Constitution, to improve democratic processes for individual members within a bicultural partnership.

In October, a highlight of our second meeting was a joint session with members of the PSA Mental Health and Addictions Committee. This the first time that the two committees had come together. Agreement was reached on areas of closer ongoing cooperation, including workforce, replacement of the Mental Health Act and the review of the MOH guidelines for seclusion and restraint. The MHNS submission on the first round of consultation on a new Mental Health law was shared with MHNS members in the March *MHNS Newsletter* and is available [here](#). Our submission on the review of seclusion and restraint guidelines will be available online soon.

The October Committee meeting also received updates from MHNS representatives in external working groups. We heard from Jennie Rae that the Mental Health, Addictions and Intellectual Disability Advisory Group to Safe Staffing Healthy Workplaces Unit (with the PSA, Central Technical Advisory Services and Directors of Mental Health Nursing) was exploring the extension of CCDM and Trendcare into Community Mental Health Services, which would further increase staff time spent on data entry and may also cut across NZNO claims in CA bargaining for nursing ratios in areas currently without CCDM.

Helen Garrick reported back on the “Future of Mental Health, Addiction and Disability Nursing” collaborative. This group was formed after Mental Health Nursing leader groups were approached to develop a publication on what was needed to take Mental Health Nursing into the future. The aim was to build on the 2006 [Mental Health Nursing Framework Discussion](#) document. The collaborative involves Te Ao Māramatanga NZCMHN, NZNO MHNS and the Directors of Mental Health Nursing.

Papers on recruitment and retention, Māori MH&A nursing, supervision, leadership, research, skills mix, Nurse Practitioners, standards of practice and education have been written. These papers will be out for consultation and feedback soon.

The Mental Health Staffing Retention Working Group (PSA, Te Whatu Ora and TAS) no longer had NZNO representation after a decision earlier in the year to withdraw, without consulting the MHNS committee. We have succeeded in reversing that decision.

Finally in October, we discussed feedback from NZNO Conference/AGM. MHNS was concerned about Constitutional Remit 2 which was passed, which appeared to bar dual union members from holding office. We are seeking from the NZNO Board that the Remit will not affect the operation of our Committee.

Save the date – MHNS Forum 2023

After two attempts to organise an educational Mental Health Nurses Forum in 2021 and 2022 were agonisingly defeated by the COVID-19 pandemic, MHNS is excited to announce our rescheduled event:

Mental Health Nurses Section Forum

Theme: Capacity in the Mental Health Arena

Friday 24 March 2023 in Wellington

A full line-up of speakers will be announced in the New Year.

IJMHN, Vol. 31 No. 6, December 2022

The *MHNS Newsletter* showcases the *International Journal of Mental Health Nursing*. Full access to the journal is a benefit of MHNS membership. To obtain an article, please email library@nzno.org.nz with the citation of the full text article you would like.

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Crowe, M. (2022), Psychiatry and/or recovery: a critical analysis. *Int J Mental Health Nurs*, 31: 1542-1551. <https://doi.org/10.1111/inm.13072>



PERSPECTIVE

Psychiatry and/or recovery: a critical analysis

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ABSTRACT: *This perspective paper aims to present a personal viewpoint on the impact of psychiatric discourse on the principles of recovery in mental health care. Mental health services espouse these principles, yet psychiatric discourse remains the dominant model. A critical analysis will examine how psychiatry maintains this dominance. The aim is to examine how psychiatric discourse constructs both the nature of mental distress and its treatment, and how it maintains its power as the dominant authority and its relationship to recovery principles. The paper concludes that psychiatric discourse is the antithesis of recovery principles and that its authority is perpetuated through co-opting a medical explanatory model, claiming expertise in the ability to predict social risk, and maintaining a tightly controlled echo chamber. A way forward involves the dismantling of the hierarchical service delivery model based on psychiatric discourse and replacing it with a more horizontal service delivery model in which the lived experience of mental distress is central. Regular audit of services needs to prioritize recovery principles. The implications for mental health nursing are considered.*

KEY WORDS: *critical analysis, nursing, recovery.*

AIM

This perspective paper aims to present a personal viewpoint on the impact of psychiatric discourse on the implementation of principles of recovery in mental health services.

BACKGROUND

This perspective paper was prompted by a question that has concerned me for some time: After two decades, why is it that recovery principles have had a minimal impact on the way mental health services are delivered and the care available to those experiencing mental distress? Other studies have identified a struggle to implement recovery principles in a psychiatric setting because of the power imbalance and psychiatric dominance (Cleary *et al.* 2018; Orjasaeter &

Almvik 2022; Otte *et al.* 2020), but the processes that perpetuate this have not been previously explored.

Governments around the world espouse recovery principles in the delivery of mental health care (Australian Government National Mental Health Commission 2017; Department of Health 2021; Mental Health Commission of Canada 2012; Ministry of Health 2021). However, there is an expectation they be integrated into the existing culture of mental health services. Institutions responsible for mental health service delivery espouse the importance of recovery principles, and medical and nurse education incorporates recovery-focused modules, but there is little evidence of this in everyday clinical practice.

There have been 55 high-profile public inquiries relevant to mental health held over the last 30 years. Despite an enormous effort by the community generally, and by people with experience of mental health care specifically, to effect change in the mental health sector through formal inquiry processes, key recommendations for mental health care 30 years ago remain current issues today (Francis *et al.* 2022). The World Health Organization Report on Mental Health (World Health Organization 2022) also identifies nothing much has changed in the past 30 years and that mental health

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Declaration of conflict of interest: Marie Crowe is a member of International Journal of Mental Health Nursing Editorial Board.

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Accepted September 01 2022.

systems and services remain ill-equipped to meet people's needs. The latest New Zealand review identified that despite the current levels of investment, psychiatric services are not delivering the required outcomes, and even when they respond to people with a mental illness, they do so through 'too narrow a lens' (He Ara Oranga p.11). An Australian review (Commonwealth of Australia 2015) identified that service delivery is based on the needs of providers, rather than on consumer choice and a 'one size fits all' approach to service delivery that does not optimally match or meet individual needs. These reviews all point to ongoing and serious problems in the delivery of mental health services.

METHOD

The principles of recovery will be briefly described to provide a basis for later comparison with psychiatric discourse. This will be followed by a critical analysis of how psychiatric discourse obtained its power and influence, and the strategies used to maintain and reproduce this. The questions directing this analysis will be:

1. Why has there been little change in the way mental health services are delivered despite ongoing recommendations for change?
2. What strategies are used to enable psychiatric discourse to maintain and reproduce its dominance and authority?
3. What effect does psychiatric discourse have on the practice of recovery principles?
4. How does psychiatric discourse compare with recovery principles in relation to ontological positions, aetiological positions, evidence base, focus, nature of the relationship, therapeutic task, and prognosis?

Design

This perspective paper aims to examine why recovery principles are often peripheral and not integral in mental health services by critically analysing psychiatric discourse, particularly the strategies employed to maintain its dominance. Critical analysis acknowledges that contemporary structures and practices have a historical basis and that individual and cultural behaviour, practices, and beliefs are framed and influenced by historical and structural factors. Psychiatric discourse is not about individual psychiatrists but rather is a particular set of values, knowledge, and beliefs that determines what can happen in practice.

Discourses shape how we understand ourselves and others and how we act about this. Fairclough (1992) outlined three ways in which the constructive effects of discourse are evident: they contribute to the construction of subject positions (socially acceptable ways of being in the world); they construct social relationships between people; and they contribute to the construction of systems of knowledge and belief (e.g. psychiatry). To maintain dominance, there are particular discursive strategies to ensure its reproduction.

Recovery principles

Recovery has been defined as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles and a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness (Anthony 1993). It provides an approach to mental distress that places the whole person with lived experience at the centre. The emphasis is not on a reduction of the person to a set of symptoms but is holistic and cooperative (Llewellyn-Beardsley *et al.* 2019). Human behaviour is interactive and inextricable from its social and cultural context. The meaning of behaviours can only be understood in this context (Middleton & Moncrieff 2018).

The principles of recovery have been described by the American Psychological Association consensus statement that included 'patients, health-care professionals, researchers, and others (American Psychological Association 2012) as self-direction, individualized and person-centred care, empowerment, and participation in decision-making, holistic, non-linear, strengths-based, peer support, respect, responsibility, and hope. A key conceptual framework for describing recovery that has similar principles (Leamy *et al.* 2011) involves connectedness, hope, optimism, identity, meaning and purpose, and empowerment. A sense of control over one's life, a sense of self-mastery, and realization of adaptive capacity have been identified as core elements of recovery (Kerr *et al.* 2020). Damsgaard *et al.* (2021) identified loneliness, isolation, and being seen as equivalent to their diagnosis as an obstruction to recovery, causing doubt as to who they were as a person.

The generalizability of the concept of recovery remains a concern in relation to non-Western cultures (Slade *et al.* 2014). It has been noted, however, that some indigenous cultures such as Māori do not see the individual as discrete from their whanau (family) or iwi (tribe) and that their experiences are more important

than a diagnosis for one of their individuals and their diagnosis. (Staps *et al.* 2019).

Receiving a psychiatric diagnosis can be experienced as standardizing, objectifying, and stigmatizing (Damsgaard *et al.* 2021). For the recovery journey to proceed, people with lived experiences of mental distress need to feel visible as people and have their voices heard. People experiencing mental distress typically experience a loss of self and identity that needs to be worked through for recovery to become possible (Kerr *et al.* 2020). The therapeutic task is for the individual to redefine themselves and reconstruct a new sense of self (Deegan 2002; Slade 2009).

Psychiatric discourse

There are some very good historical accounts of the emergence of psychiatry and how it institutionalized its power by aligning with medicine [see e.g. the work of Scull (1979, 2021b, 2022)]. One strategy used to bolster its power was to lay claim to knowledge of the distinction between normal and abnormal behaviours by naming any discrepancy as evidence of mental disorder. It has been proposed that psychiatric discourse sets the parameters of normality and abnormality, around social and cultural expectations of productivity, moderation, unitariness, and rationality (Crowe 2000). It defines mental disorder as an absence or deficit of these social norms under the guise of some biological causation. Yet psychiatry has been unable to solve questions of causation, and while biology predisposes some people to heightened vulnerability, this is not disorder-specific (Scull 2021a).

Psychiatric discourse is focused principally on diagnosis, containment, and drug treatment. It bases its claims to legitimacy and privilege on the medical model, and, to do this, mental distress is aligned with medical diseases as evidence of biological deficit. However, despite decades of intensive research, there is no substantive biological evidence that mental disorders are diseases in the medical sense. In the absence of genetic markers that align with diagnoses, psychiatry has undertaken considerable research in the past two decades into identifying peripheral biomarkers (e.g. cortisol responses, vitamin levels, inflammation) that could provide evidence for mental disorders. However, as identified in an evidence-based umbrella review of 162 potential peripheral biomarkers there was very little evidence to support any consistent association (Carvalho *et al.* 2020). The diagnosis and clinical management of major mental disorders are based on psychopathology

while treatment remains predominantly based on 'trial and error' (Leucht *et al.* 2012). In medicine, symptoms are subjective evidence of underlying disease or physical disturbance, but in psychiatry, the disease or physical disturbance has not been sufficiently established. The congruence in diagnostic processes between psychiatry and medicine is tenuous at best.

There is very little similarity between the basis of medical diagnoses and psychiatric ones. In medicine, an explanation of the illness employs knowledge derived from empirical natural sciences, which enables the illness to be understood as the result of disturbed anatomy or physiology but there is no such biological evidence available in psychiatry (Moncrieff & Middleton 2015). While there has been scientific progress made in psychiatry, the clinical utility of the findings to date has been very limited and the necessary aetiological understanding of the various categories of mental disorders does not exist. (Scull 2021a).

Despite this, diagnosis is the cornerstone of psychiatric discourse. People in mental distress are given a diagnosis as defined in either the Diagnostic and Statistical Manual-5 (American Psychiatric Association 2013) or the International Classification of Diseases (World Health Organization 2019). The DSM-5 task force initially claimed that all diagnoses in the most recent diagnostic manual would be underpinned by biological markers, unlike previous manuals. However, in the absence of consistent biomarkers, the task force abandoned its attempts to provide evidence to support its ever-expanding diagnoses and stuck to the use of expert consensus. The mental disorders enumerated in the DSM-5 are historically contingent and vulnerable to social and political influences (Kendler 2016). They often reflect the research, insurance, commercial, and financial interests of the task group members. It has been identified that there were financial ties between DSM panel members and pharmaceutical companies (Cosgrove & Vaswani 2019). The ICD-II also used expert consensus in the absence of biological evidence but was perhaps more inclusive in who it sought opinions. Psychiatric diagnosis effectively constructs the individual's past, present, and future and determines treatment and prognosis, while also promoting stigma. By claiming to know and name what is happening to the person experiencing mental distress, psychiatry bolsters its claims of 'expertise'. There is accumulating evidence that these explanations contribute to stigmatizing attitudes (Schroder *et al.* 2020).

Psychiatric diagnoses and treatments are also culturally biased. Diagnoses are based on western assumptions

of what constitutes normal behaviour (Crowe 2000), and many studies of psychiatric treatments do not include indigenous people, and clinical trials generate findings that are not generalizable across ethnicity (Burkhard *et al.* 2021). Drug treatments are the primary, and almost exclusive, therapeutic modality in psychiatry. The basis for prescribing drugs is related to presumptions of biological abnormality that contribute to biological effects that give rise to mental disorders. However, using depression as an example, despite huge amounts of research, a systematic umbrella review of the evidence (Moncrieff *et al.* 2022) reported that there is no convincing evidence of a biochemical basis for depression. In addition to limited efficacy, there is also emerging evidence that selective serotonin reuptake inhibitors and serotonin and norepinephrine reuptake inhibitors are associated with high rates of adverse effects in the personal and interpersonal domains and high rates of withdrawal effects (Timimi *et al.* 2018).

I propose that it is the dominance and authority of psychiatric discourse and the way in which it maintains its power, that prevents meaningful change in mental health services. Given the limited evidence to support its biological legitimacy and government reviews recommending alternative approaches, it is curious that psychiatric discourse continues to maintain its authority and power. Although psychiatric knowledge is weak, psychiatric authority is powerful (Pilgrim 2013). I suggest three strategies are at play in reproducing the dominance and authority of psychiatric discourse. The first is to embed itself in medicine, as discussed above. In addition, to maintain its authority psychiatric discourse lays claim to expertise in identifying and managing social risk and perpetuates its power through an echo chamber that reinforces opinion under the guise of evidence.

Psychiatric discourse claims to be able to identify and manage social risk, that is, the risk to self or others. By asserting this expertise, it has the power to compulsorily detain and treat people who pose a risk. Psychiatrists are brought in as risk consultants by claiming an ability to predict future behaviours (Rose 2018). Under the New Zealand Mental Health Act (Compulsory Treatment and Assessment; NZ Government, 1992), a person can be compulsorily detained and treated if they are assessed as having a mental disorder. In this context, mental disorder means an abnormal state of mind (whether of a continuous or an intermittent nature), characterized by delusions or by disorders of mood or perception or volition or cognition, of such a degree that it (i) poses a serious

danger to the health or safety of that person or of others, or (ii) seriously diminishes the capacity of that person to take care of himself or herself. However, there is little evidence to support the specificity and accuracy of risk assessment in predicting harm to self or others. There is an absence of research evidence supporting the ability of violence risk assessment tools to reduce or prevent adverse events despite the widespread reliance on these tools which can provide a false sense of security that risk has been adequately addressed (Wand 2012). Because there are problems associated with predicting the risk of harm to others and there is a tendency of psychiatrists to err on the side of safety, '[t]he dangerousness criterion effectively condones the detention of many mentally ill people who will never become dangerous, so that it might capture the few who will' (Large *et al.* 2008). Suicide risk assessments also have only modest discriminating power (Large & Ryan 2014). Alongside concerns regarding the validity of risk assessment in predicting suicide, there is also a strong argument that such practices implemented by health services to manage risk, such as formal observations, can be countertherapeutic and carry many costs to those with lived experience (Manuel *et al.* 2018). A key determinant in the process of risk assessment is the person's psychiatric diagnosis; however, those with lived experience have suggested that increase in the risk of harm is linked to the clinical culture (Fletcher *et al.* 2021).

From its inception, psychiatry became not merely a scientific enterprise but a social enterprise because of its mandate to control social deviance and social risk. Particular attributes, characteristics, or behaviours are regarded as signs of potential risk, and this calculation of probable risk effectively constructs an individual's past, present, and future in a particular way that poses a social threat (Crowe & Carlyle 2003). The claim that psychiatric discourse can identify and manage social risk is now integral to not only our mental health services but also our justice and insurance systems. This is despite very limited evidence that such risk can be predicted.

The final strategy that reproduces the power of psychiatric discourse I have termed the 'echo chamber', which is perhaps the most effective strategy. The echo chamber refers to self-affirming and self-filtering processes that give voice to like voices and beliefs (Noar 2021). The term 'echo chamber' has emerged from the discussion of how Internet communities become entrenched in sites that give voice to opinions constructed as facts. The term can also be applied to

the processes by which psychiatric discourse maintains its authority: controlling what constitutes clinical guidelines. The influence of pharmaceutical companies on psychiatry is well documented. The combined commercial and professional self-interests result in undue influence over what diagnostic and treatment recommendations are included in treatment guidelines and taint them as untrustworthy (Cosgrove & Vaswani 2019).

Clinical treatment guidelines claim to be developed using a systematic evidence review of published psychiatric papers supplemented with consensus expert opinion (Lam *et al.* 2016; Malhi *et al.* 2021; National Institute for Health and Care Excellence 2018). While medicine has increasingly relied on evidence from systematic reviews for clinical guidelines and diagnosis, psychiatry has relied on 'expert consensus in the absence of evidence' (Kendler & Solomon 2016). To explore this further, I analysed recent treatment recommendations for mood disorders from the Australian and New Zealand College of Psychiatry (Malhi *et al.* 2021). The analysis of the recommendations in these guidelines identified that 60% were 'consensus-based evidence', and only 26% of recommendations were supported by Level I or II evidence, that is, well-supported, efficacious treatments, or probably efficacious treatment.

The basis for these claims of expert consensus is, however, poorly described. These guidelines have not described the usual process for medical expert clinical consensus which is developed in working groups using structured and transparent approaches, for example the Delphi technique, nominal group technique, or consensus conferences for developing consensus (Black *et al.* 1999). Clinical guidelines in psychiatry are highly cited, and there is an assumption that recommendations are derived from scientific evidence; however, a closer look suggested it was mostly 'expert' opinion. The guidelines are highly cited as evidence to support further published opinion and research, and the previous guidelines (Malhi *et al.* 2021) garnered 742 citations times (Google Scholar August 2022). These citations can then be used to reinforce published opinions which can then be used to support future guidelines. A circular process of production and reproduction of psychiatric discourse occurs in which opinions are echoed back and forth to create the illusion of expert consensus. An echo chamber is created in which the key features of psychiatric discourse become truths under the guise of science. In the absence of a description of a rigorous and transparent

process describing how expert consensus was obtained, it may be assumed that it is the opinion of the authors and perhaps a small review panel. The evidence for the recommendations provided is weak, yet the guidelines continue to assume credibility that perpetuates their role in the echo chamber.

In summary, psychiatric discourse and recovery principles have little in common. An evaluation of how psychiatric discourse is enacted in relation to recovery principles identified that psychiatric discourse provides the direction of assessment and treatment rather than enabling self-direction; is a diagnosis-driven process rather than being individualized and person-centred; marginalizes the voices of those with lived experience rather than empowering those voices; has a focus on biochemical deficits rather than a holistic focus; is tokenistic in including those with lived experience in decision-making; is linear in its focus with assessment, diagnosis, and prescription driving the direction; is medication-reliant rather than strengths-based; positions those with lived experience as passive 'patients'; and fails to instil hope by constructing psychiatric disorder as a biological entity that can lead to ongoing relapses.

Recovery and/or psychiatric discourse

To understand this divergence between psychiatric discourse and recovery principles, the two were analysed in relation to some key attributes: knowledge base, ontological position, aetiological position, evidence base, focus, nature of the relationship, therapeutic task, and prognosis. The analysis revealed that the core characteristics that underpin recovery principles are the antithesis of psychiatric discourse as I have described in Table 1.

The two approaches to mental health care have nothing in common, and attempting to integrate the two into mental health services without positive action in terms of resources and authority will perpetuate the dominance of psychiatric discourse and position recovery principles as a peripheral value with limited impact on mental health services. Lived experience is as valid of a form of knowledge as psychiatric discourse but it currently lacks the authority. Recovery principles have been made to fit a health infrastructure where their meaning is shaped by a traditional focus on hierarchy, clinical tasks, professional language, medicalization, and psychiatric power (Le Boutillier *et al.* 2014). While the rhetoric is abundant, the reality is that the language of recovery is used to create an illusion. The power

TABLE 1 Core characteristics recovery and psychiatry

	Recovery	Psychiatry
Knowledge base	Experiential	Reproduction of medical model
Ontological position	Holistic and person-centred	Categorical and reductive
Aetiological position	Trauma, social, and cultural stressors	Biological deficit
Evidence base	Narratives of experience	Limited biological evidence
Focus	Behaviour, thoughts, and feelings	Search for symptoms of underlying deficit
Nature of relationship	Active participation	Passive recipient of 'expertise'
Therapeutic task	Reconstruction of new sense of self	Diagnosis and medication
Prognosis	Hopeful of change	Recurrence and stigma

embedded in diagnosis and medication based on 'evidence' or 'expertise' continues to thrive. Discrepant priorities across these different levels of the health system lead to a clash of paradigms and competing agendas in supporting recovery, with practice most often dictated by power within the system (Le Boutillier *et al.* 2014). I suggest that the illusion of the current 'recovery focus' embedded in psychiatric discourse within psychiatric services perpetuates stigma, likely undermines recovery, and expedites recurrence of mental distress.

There is a distorted demand for psychiatric care that is based on an ever-expanding notion of what constitutes a psychiatric disorder compounded by an inaccurate gauge of the efficacy of psychiatric treatments, particularly pharmacological ones (Steingard 2019). The lack of availability of psychiatric treatment is a popular topic across many forms of media. Stimulating the demand for psychiatric services has been an effective strategy for shoring up the psychiatric discourse. There is a need to radically broaden what counts as knowledge and whose knowledge counts (Rose & Kalathil 2019).

People who experience mental distress experience injustice when their identities are devalued through the acquisition of psychiatric diagnoses which in turn leads to stigmatization (Harper & Speed 2014). Institutional structures create injustice where there are disparities in resources, opportunities, and representation between majority and non-majority perspectives, for example, inequalities in access to treatment, experiences of health services, and treatment outcomes (Hui *et al.* 2021). It occurs when treatment or services cause

harm, even when the professed intentions underpinning the institution are benevolent. It is characterized best through epistemic injustice which occurs when the person seeking treatment is not listened to or taken seriously, is regarded as not understanding their experiences, and is not considered a reliable source of knowledge or information (Drozdowicz 2021). The 'patient' is side-lined in an epistemic search for diagnosis and medication. It occurs when a person's treatment preferences are dismissed because the psychiatric diagnosis attributed to that person suggests an inability to think rationally or clearly (Kurs & Grinspoon 2018). In the face of this institutional injustice, it has been suggested that at the clinician level approaches are needed to avoid two related dangers: diagnostic overshadowing in which a person's experiences and physical symptoms are misattributed to mental illness and granting master status to one aspect of a person's identity by disregarding other aspects (Hui *et al.* 2021). Given the chasm of differences between recovery principles and psychiatric discourse and the injustices embedded, is it possible to build a bridge between the two?

RELEVANCE FOR CLINICAL PRACTICE

Recovery principles and psychiatric discourse are fundamentally dissimilar. However, if the authority embedded in psychiatric discourse can be contested and recovery principles are privileged, then it may be possible that psychiatry plays a role where it supports recovery, where it places the needs of those with lived experience over the need to maintain dominance. Mental health nurses have internalized the social positioning imposed on them by the long-standing hegemony of medicine and more recent deference to psychology (Lakeman & Hurley 2021). Although they are often complicit in maintaining psychiatric discourse, they also paradoxically engage with discourses more aligned with recovery principles (Joergensen & Praestegaard 2018). However, they do have a range of less dominant discourses that they engage with. It has been identified that nurses engage with both technical (medical) and caring discourses while remaining largely silent (Canam 2008). Mental health nurses comply with the bureaucratic system of mental health care while using the same system to ensure the needs of those with lived experience are met and as such are in an empowered position to renegotiate the characteristics of mental health services (Hurley *et al.* 2008). The caring discourse is often invisible in the face of psychiatric discourse.

This discourse needs to be more visible to support recovery principles. Several models have been proposed to do this (Barker 2001; Daya *et al.* 2020; Santangelo *et al.* 2018) but barriers to their implementation persist (Harris & Panozzo 2019). In the context of psychiatric discourse, the mental health nursing role is often confined to the provision of custodial care (risk assessment, special observations, and seclusion) in the acute phase and risk management and promotion of medication adherence during the sub-acute phase (Crowe 2017).

No mental health service (or peer-led service) can genuinely claim to promote recovery principles at the same time as psychiatric discourse dominates. The current issues facing access to mental health services and effective treatment do not mean we need to further expand current models of service delivery; more resources need to be provided to services that incorporate recovery principles. One way to do this is to instigate service audits and key performance indicators that privilege recovery principles. Rather than prioritizing the current key performance indicators (reducing restrictive practice, improving service transitions, improving medication management and prescribing, learning from serious adverse events and consumer experience, and maximizing physical health; Health Quality and Safety Commission New Zealand 2021), recovery principals should be given priority. Services could be audited in terms of individualized and person-centred care in which the individual or their family determines treatment, empowerment and genuine participation in decision-making, treatments determined in consultation with those with lived experience, holistic rather than purely diagnosis-driven, active peer-support at all stages of assessment and treatment process, and respect for the individual's needs rather than the organization's.

Recovery-based services need to be led by those with lived experience with clinicians providing support to facilitate connectedness, hope, optimism, identity, meaning and purpose, and empowerment. Services would no longer be structured around diagnosis but rather the clinician and the person in mental distress and their family would work together to develop formulations based on predisposing, precipitating, perpetuating, and protective factors (Crowe *et al.* 2008). This 4 P model examines the events and patterns in the person's life that contribute to their current distress. It can produce meaningful context-specific formulations, reflecting the person's social and cultural needs instead of decontextualized diagnoses into which both the

person and their mental distress are shoe-horned. These formulations would form the basis of treatment.

Treatment might involve the short-term use of medication to manage the behaviours, thoughts, and feelings associated with mental distress. Medication would be prescribed by psychiatrists or nurse practitioners; however, I propose this would be a technical role to support the person in their recovery – a psychiatric technician. Medication cannot treat any assumed underlying cause, but it can bring relief and the opportunity to step back from an overwhelming crisis.

Rather than focusing on risk and containment of mental health, nurses could provide therapeutic interventions based on fostering connectedness, hope, optimism, identity, meaning and purpose, and empowerment. Evidence for the effectiveness of these interventions would not be based on 'symptom reduction' but rather on the experience of those who are recipients.

CONCLUSION

Psychiatric discourse maintains and reproduces its power through its alignment with medicine, its claims of expertise in identifying and managing social risk, and maintaining its own echo chamber that utilizes publication strategies to enforce its position. There is no congruence between psychiatric discourse and recovery principles in either how it is enacted in practice or its philosophical underpinnings.

The agenda for change is urgent because of the injustices that pervade mental health services dominated by psychiatric discourse. Mental health nurses need to accept this as a challenge to promote models of service delivery and treatment that are not embedded in psychiatric discourse. Institutional transformation is required with the greater authority given to transdisciplinary approaches (Hui *et al.* 2021) that position those with lived experience as central. We need to promote the need to audit recovery principles as key performance indicators, and we need to shift from reinforcing psychiatric discourse to negotiating reforms that privilege lived experience.

ACKNOWLEDGEMENT

Open access publishing facilitated by University of Otago, as part of the Wiley - University of Otago agreement via the Council of Australian University Librarians.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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