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The crisis of futility: clinical ethnography and the moral landscape of community psychiatry

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This paper is about the narrative of progress in contemporary American psychiatry and the way it collides with the lived experience of front-line clinicians. How do clinicians respond when they are pushed to endorse the narrative of progress, even as they watch their treatments fail? I explored this question during two years of fieldwork with a community agency mandated to provide all medical and social services to about 75 individuals with serious psychiatric disorders. The work team follows the model of Assertive Community Treatment, which is probably the most well researched type of outpatient treatment for people with severely-disabling schizophrenia, depression, and bipolar disorder. We know it in our discipline through Sue Estroff's book, Making It Crazy (Estroff 1981), which laid out this model's core contradictions for the lives of clients. In the larger project from which my paper is drawn, I shift the focus to clinicians and the way they negotiate the frustrations and impossibilities of their job.

I pay special attention to the grounded ethics – or everyday ethics – of the work team. What provokes these psychiatrists and social workers to frame their ordinary frustrations and extraordinary crises in ethical terms? When do they decide to move beyond a technical, clinical language and take up questions of right and wrong, of the obligatory and the forbidden? Where do they draw the line separating the technical from the moral, how do they defend this line, and why do they sometimes breach it? These are the basic ethnographic questions about everyday ethics (see Brodwin 2008).

My questions dovetail with the concerns of this panel in the following way. By definition, everyday ethics emerges in the here-and-now of clinical work. Ordinary clinicians in this setting training often make spontaneous comments about high-order issues such as free will, coercion and the legitimate uses of power. After all, Assertive Community Treatment involves massive intrusion in and surveillance of virtually all areas of clients' lives. People's comments, however, are always indexical. They begin from and refer to concrete hands-on practices. People's ethical reflections arise from attempts to meet the demands of the day, using the tools at hand. In my talk today, I will look at how the expectation for continual improvement is woven into this tool, how people use the tool, and how the frustrations and impossibilities they encounter along the way form the background for their everyday ethics of futility.

One of the core tools in this setting, it turns out, has a built-in narrative of progress. I am speaking of treatment plans (see handout). Treatment plans are banal but ubiquitous bureaucratic documents. They are a paperwork technology: technology that these providers use to transform a person into a patient, that is, an object of work whose needs fit the available expertise. A completed treatment plan illustrates what Foucault called "disciplinary writing" (1979: 190 ff). It locates an individual within the categorical schemes endorsed by a given professional cadre. It documents someone's features in ways that enable clinical action; i.e., that will "discipline" the person according to professional norms of conduct.

Therapeutic progress as such is a fundamental norm written into the very document in your hands. All treatment plans resemble each other, and they operate ideally in the same way. The writer must imagine a patient's future, inscribe it, and then use this trajectory to determine clinical action in the present. Look at the categories waiting to be filled: name, problem, goal (short-term and long-term), intervention, and the metrics to gauge progress towards the goal. They line up in a single logical chain, each link justifying the next. The third treatment plan in the handout comes from the agency where I worked: with this paperwork tool, the suffering of clients gets transformed into a list of 2-4 discrete problems; each problem is linked to 2 concrete and quantifiable goals (located 3 and 6 months in the future). Each goal, in turn, calls for a bundle of home visits, therapy groups, "support", medication, and monitoring. To operate this paperwork tool, the staff by necessity plots an arc of ever higher achievement. Every 6 months, the client supposedly takes two incremental steps to address each problem. The very act of writing a treatment plan demands a story of progress.

The function of treatment plans is more complicated than the documents themselves. Look again at the example from the pseudonymous Eastside Services (p. 3 of handout). Its intends to stage clinical action and advance the agency's core mission of reducing symptoms and stabilizing community residence. At the same time, clinicians must complete the plan to ensure the fiscal survival of their workplace. This agency depends on public monies, and every two years the state sends an auditor to certify it for continued funding. On his site visits, he combs through the treatment plans and checks to see if the goals are measurable, if they chart a feasible route of progress over time, and if progress notes line up with the goals. Incomplete or disorganized paperwork endangers the continued existence of the agency. The pervasive "audit culture" of public sector health services powerfully affects how people fill out these forms. From one angle, the clinical and bureaucratic rationales for treatment plans seem quite different, but they both issue the same mandate for a measurable and continual story of improvement.

Front-line mental health workers actually have a great difficulty using this paperwork. The built-in narrative of progress runs up against obstacles implicating the client, the agency, and the public mental health system as a whole. As a matter of paperwork, however, people must avoid admitting defeat. In the end, they develop a counter-narrative: spoken, not written; involving black humor, not optimism; and aimed at the minimal goal of maintaining contact, not the ideal of continual improvement. In the rest of this paper, I examine this counter-narrative, produced in the gap between the ideal of treatment planning and the reality of everyday practice. (In other writings I show how it illuminates people's emergent ethical commentaries.)

Writing treatment plans is a recurrent activity at daily staff meetings. The discussions always start with the broad objective for a given client (stable housing, decreased symptoms, less isolation, etc.). [The forms are generic, but…] Choosing the precise problem and goals, however, is not a ready-made procedure. To the contrary, people must often self-consciously figure out how to insert a chaotic life into an orderly story-line that justifies their interventions. Consider someone spiraling into a crisis of drug use, worsening symptoms, and criminal behavior. When the treatment plan came due for the pseudonymous Matthew Holmes, he was binging on alcohol and cocaine, had stopped eating (so his weight dropped dangerously low), and had allowed drug dealers to take up residence in his apartment. The team chose 4 problems (alcohol and drug abuse, housing, psychiatric symptoms, and medical danger), but still could not see their way out of the crisis. One case manager volunteered,

> I don't know a goal for AODA. He won't go to group. There are always people in his apartment, so we can't monitor his use. For psych and medical, he never takes his medications on the weekend. Because we always see his pills in the med cassette. We are still telephoning him, but it doesn't work .… What's our role? It's so limited with him.

The discussion continued, but the team could not find a way to intervene in Matthew's downward slide. They finally settled on three main goals: that he take his medications five days a week, that he maintain his current housing, and that he agree to being weighed once a month. But by the meeting's end, the team was still frustrated. Capturing the mood, the supervisor sarcastically re-phrased the 3 goals: "Take these [meds], stay in your housing. Take these, here's your food. Take these, don't die."

Her black humor carries the counter-narrative of progress. Even with their long experience with Matthew and their arsenal of clinical tools, the clinicians had lost control. If they cannot enter his apartment, they cannot monitor his drinking and drug use, and they cannot watch him take medication. Matthew resists all attempts to move him along the standard therapeutic trajectory. Nonetheless, the team must write something in the treatment plan, so people retrenched to the minimal goal of treatment adherence ("Take these…"), pessimistic about their chances of success.

The ideology of progress, as sedimented in the treatment plan, means that people must continually defer their clinical frustration or express it in another register. People resort to yet a third strategy with the large group of clients who simply show no desire to alter their current situation. Such people do not teeter on the brink of disaster or resist the team's services. But they frustrate all attempt to place them on an upward trajectory. Alex Moore exemplifies the frustration. After a psychotic break in his mid-twenties, Alex experienced a long period of homelessness and was admitted to the agency twelve years ago. Since then, he has lived in a dilapidated room and board residence and spends most of his time alone. After reviewing his last 6 months during a treatment planning session, the supervisor wondered out loud:

> Supervisor: Is there anything that bothers him? Stresses him out? No. He's like Teflon. He leads a crappy life, but he just sails along.. … You should do the recovery questions.

The supervisor then pulled out a printed list of 29 questions entitled “Achieving Personal Recovery: Outcome-based Assessment and Planning,” published by the state Bureau of Community Mental Health. This list is an add-on tool, a plug-in technology, that people deploy when goal-setting grinds to a halt. Some of the items on this list are open-ended questions about selfhood and emotions:

> No. 1. How do you see your life different 3-5 years from now?
> No. 2. If you could wave a magic wand and change one thing in your life, what would it be?
> No. 3. When are you most happy? Sad? Angry? Frightened?

Others invite people to report on their experience of psychiatric illness:

> No. 19. When things are not going well for you, how do you know? What is happening around you? Inside you? What are you doing? Not doing? Who is there? Not there?
> No. 20. When you went into (crisis) (hospital) in the past, what was happening just before? What do you think might have prevented that situation?

Browsing the list, the supervisor devised an approach for Alex. She told the case manager to bring some coffee to his apartment and say, “Let’s sit in front of the building and talk.” This innocuous idea became inscribed as the long-term goal “Client will discuss one time how he knows things are not going well,” a version of recovery goal no. 19. Of course, these questions can apply equally to all the clients, so they get used mainly a last-ditch effort to insert people into the requisite narrative of progress. The supervisor only brings them out when she cannot come up with any other option.

The frustration in this case, however, lies below the surface. The printed list of questions is a product of the broader recovery movement that has influenced mental health policy nationwide and in Wisconsin (see Jacobsen 2004).[1] But the way people at Eastside Services actually use the list contradicts that movement’s egalitarian and hopeful ethos. PIn principle, the perspective of case managers should fit the recovery ideology. According to the founders of ACT, all services should be planned in accordance with clients’ needs, strengths, and preferences (see Stein and Santos 1998: 33). The textbook instructions for treatment planning re-iterate this point: the self-interest of clinicians or the structural features of the health care system should not supplant the clients’ own needs and perspective (see Allness and Knoedler 2003). But when the front-line

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[1] Supervisors are exposed to the movement in day-long seminars offered by the county mental health department, and they keep on their bookshelves practical handbooks such as the Wellness Recovery Action Plan (Copeland 1997) and The Power of Procovery in Healing Mental Illness (Crowley 2000).

clinicians cannot figure how to provide any services at all, the principle of "client-centered treatment" loses its urgency.]]

What can the team do when faced with someone like Alex ? He has made very little apparent progress since admission, and he has no interest in the team's services. The team retrenches to "recovery questions," but uses them for purposes far from their original intent. The recovery movement in mental health has an egalitarian and hopeful ethos. The list of 29 questions invite explorations of people's dreams, their fears, or their experience of illness. By posing them, however, the team aims not to renew clients' sense of possibility or repair the damage to selfhood caused by severe mental illness (see Hopper 2007). They aim simply to keep clients in contact with the agency. "Recovery questions" are essentially place holders that case managers use when they despair of other paths towards the minimal goals of reduced symptoms and a stable, connected life.

People use "recovery questions" and black humor in the same way: to muddle through the gap between the treatment planning ideal and the demands of front-line practice. No-one even comments on the contradiction between the way they use these questions and the hopeful ethos of the recovery movement and its critique of conventional mental health practice (see Hopper 2007)

To conclude: In this paper, I ask how something as abstract as the ideology of progress is sedimented in a banal tool like a treatment plant. The question draws from a fruitful strand in science and technology studies. Clinical practice, like the everyday work of bench scientists, is constrained and enabled by the tools at hand: specific techniques, instruments, and models (to paraphrase Clarke and Fujimura 1992: 3). Looking closely at how people use such tools shifts our angle of vision from the contents of psychiatric knowledge to the ecology of clinical routines. The narrative of progress enters the scene of work, in this case, around a conference table, with a treatment plan waiting to be filled by 10 am. This is the experience-near framing of futility. The black humor and the supremely pragmatic (if not cynical) use of recovery questions show how people articulate futility in the rush of clinical work. The tool itself, the narrative sedimented within it, and the way that narrative collides with the reality of practice jointly produce the everyday ethics of the clinical front-line.