Risk, Responsivity and Responsibility in Mental Health: A Star Wars Story from Aotearoa.

Nick Drury

Psychologist

Dip.Clin.Psych.

nickdrury@clear.net.nz

Abstract

This paper contributes to the risk management or professional accountability literature by reviewing the literature that compares formal risk management systems and indigenous risk management practices. This brings to light how formal risk management systems have obscured a very poor rate of effectiveness in mental health from view and are interfering with efforts to improve these. Some diverse case examples are provided. Foucault's (and others') analysis of this situation, and a solution in the development of Parrhēsiastes (fearless truth tellers), are outlined. One form these parrhesiastes takes are supershrinks. It is argued that a shift from process to outcome not only reveals the Parrhēsiastes, but further steps to an ecology of mind.

Key Words. Risk Management, Outcome Monitoring, Parrhēsia, Mental Health, Foucault, Wittgenstein

Introduction – Two modes of Risk

Risk management systems have become the salient organising principle of modern society over the past thirty years (Beck, 1999; O'Malley 2004), and have become so widely dispersed and deeply ingrained that much of it has become like the proverbial water fish are unaware of (Power, 2004). Foucault's (2008) account of the emergence of neoliberalism showed that by casting all of us as entrepreneurs, global economic competition was increased; and "if you multiply enterprises, you multiply frictions, and you inevitably multiple judges" (to regulate the frictions) (p.139). This created the 'need' for risk management systems. Under the neoliberalism of Thatcher, Reagan, and our own 'Rogernomics' here in Aotearoa, a new form of public management emerged in the late 1980s, transforming public organizations and professions (Easton, 2002; Harvey, 2007; Ward, 2011). In health, the resulting 'managerialism' promised a reduction in risk, and gains in efficiency by delivering health as an enterprise.

However, in some domains, like in mental health, long before the arrival of neoliberal risk management systems, there were already ways of dealing with risk. Risk to self and others had always been present and methods were developed to deal with it. For many, this was not the more formalised risk-management check-lists we find now, which provide something of an objective calculation of possible danger, but the engagement of the client in a manner which ameliorated the danger (Drury & Munro, 2008). Psychiatric risk was primarily approached by skilled professionals as a therapeutic task (Mullen,

2000), as the goal was reducing or preventing the risk from manifesting[1]; which is quite different from the more neutral or passive activity of actuarial risk assessment that is being called for now in this risk averse climate (Ogloff, 2006). Whereas the earlier professional ethics-based interventions were highly dependent upon the skill of the practitioner in achieving a successful outcome; more recent risk management guidelines are more "rule based". Nowadays, a formal assessment is conducted before deciding upon a treatment plan; and in turn, more emphasis is given to a treatment plan conforming to empirically supported guidelines. As Power (2004) clarifies, the practitioner will now be judged on their adherence to a set of rules authored by the risk management system. A Royal College of Psychiatrists survey showed most psychiatrists recognised these type of risk assessments as largely useless, and primarily a form of defence "… to protect the organisation" (Szmukler & Rose, 2013). This has resulted in professional judgement and a primary concern with clinical outcome (ends) being marginalised in favour of following defensible process (means). As Power (2007) notes, risk management is now increasingly shifting its focus from first-order risk (the safety of the client and others), to second-order risk, the reputational risk to the organization or profession ('have they followed correct procedures?').

In a review of "The Munro Report" on the failures of child protection services to prevent the death and abuse of children after notification in London, excessive ritualised defensive tasks such as "various layers of assessment before action is

---

[1] Like Foucault's (1984) comments on Baudelaire – the point of seizing hold of the present is to transfigure it.

decided upon" were identified as major causal factors (Lees et al, 2013). The authors of the report go on to claim that these practices were first identified as occurring in health, by Menzies Lyth (1988), amongst nurses. Due to rising anxiety in "a blaming culture", the nurse-patient relationship was transformed. Accordingly, nurses began to complete a set of procedural tasks for all patients on the ward, and provided fewer interventions for one patient. Responsibility was thus re-distributed. Similarly, until very recently, most funding went into efficacy research throughout health, based on the notion of risk management, once we identified the most efficacious medical procedure, accountability then would focus on a practitioner's adherence to the empirically supported procedures (Chiappelli et al., 2012). Despite the considerable lengths these efficacy researchers went to, in order to eliminate the practitioner as a variable affecting the outcome, it turned out that in some domains in health, especially in mental health, the person of the therapist far exceeded any method (Duncan et al., 2010; Norcross, 2011; Wampold & Imel, 2015). The therapist variable is so significant that mandating a particular treatment may cause harm, as 'this method' with 'this therapist' with 'this client' may not harmonize. Laska and Wampold (2014) even showed that exposure to phobic stimuli, which many thought essential to any therapy for phobia, is not a necessity. Nevertheless, best practice guideline committees continue to demand that mental health practitioners only utilise empirically supported treatments, threatening "excommunication" if they don't (Cooper, 2011).

Foucault on politics and morality

Although Foucault is best known for his early writings, where he showed how docile subjects are 'fabricated' by internalizing power-knowledge technologies (e. g. drills in the army, schools and factories), and through the 'gaze' of the panopticon; his later work (e. g. 1986, 2005) provides a clearer direction for how to take political action against these subjugating forces. During this third period of his work, he turned his attention to how people could actively develop their "selves", and not just be the docile or passive recipients of (and reproducers of) the mores of society, as his earlier work had shown. He was particularly attracted to Greco-Roman culture where he saw more people being encouraged to actively constitute themselves by engaging in various ascetic exercises, so that they might engage their social world as an aesthetic and ethical work of art (Milcham & Rosenberg, 2007). The word 'aesthetic' for Aristotle (2013) meant 'imitation of life'; so it meant becoming more life-like, or what we might call 'natural', in contrast with the cultivation of "dandyism" for example (Lok Wing-Kai, 2011). Self-constitution also comprises a certain self-mastery, what certain Greeks identified in King Nicocles marital fidelity at a time when there were no rules or customs prohibiting or frowning upon extramarital relations (Foucault, 1985). In other words, this is Foucault's take on Kant's enlightenment essay, where a "human being emerges from his [sic] self-incurred minority" ("immaturity") (1784/1996, 8:35). For Kant (and Foucault) this involves a shift from obedience to the authority of another to the use of our own reason; but unlike Kant who advocated obedience at work and freedom of speech only in the public arena, Foucault suggested we find a collective expression of our "truth" at work too (e. g. the anti-psychiatry or critical psychology movements) (Foucault, 2006; Anderson & Wong, 2013).

Many have questioned whether there is a distinction between Foucault's earlier work on the fabrication of the subject and his later work on the self-constitution of the subject, as fabrication and self-constitution of subjects can be seen as two sides of the same coin (e.g., Habermas, 1987; Deacon, 2003). We are, in a way, trapped in history, as we are both the object and subject of any knowledge about us, whether we are re-writing our past (as Narrative Therapists do[2]), or giving ourselves a set of new rules (prescriptions, dietetics) on how to escape this 'fly bottle' (as many religions do). Fortunately, Foucault is not alone in helping us find "the art of not being governed quite so much" (i.e. 'enlightenment') (1997, p.29). Wittgenstein (1958), for example, helps us see that what we are calling 'enlightenment' is a matter of quite literally coming to our senses or "awakening" (Drury, 2015). Many of us now read Wittgenstein as showing us that it is more useful to look upon ourselves as sensori-motor beings constantly feeling out our relationship with our world and each other to maintain a way forward, much like the blind man with his cane (Drury, 2013). This has led to the development of the science of Radical Embodied (extended) Cognition, where we 'think' with our bodies, as we subtly re-position ourselves to maintain our 'attunement' (Chemero, 2009; Hutto, 2012). Unlike for Descartes and Kant, 'mind' or consciousness is no longer usefully viewed as being in our heads, but lies in the interactions between ourselves and our world (Noë, 2009). This is similar to the

[2] Albeit, a more preferred history in therapy. For some religions (e. g. Tibetan Tantra), reincarnation or samsara is a metaphor for within life changes, but the problem still remains of how to get off the wheel of 'death' and 'rebirth'. An interesting solution has been offered by the philosopher Galen Strawson (2004) who claims that it is not necessary for us to be telling a narrative of a continuous self; but serial 'selves' instead, which we are not so attached to.

Zen doctrine of no-mind (Suzuki, 1949), or moving about as if one had no head (Harding, 1961), and closer to many indigenous ways of thinking (Drury, 2011).

Further light is shed upon this emerging new (old) paradigm, of human capacity to be highly attuned to each other and nature, via the 'ethics-first' philosophy of Levinas (1998). Like Wittgenstein, Levinas sees "an immediacy" in our responsiveness to each other (Overgaard, 2007). There is no Cartesian homunculus or Kantian transcendental mind that has us standing apart from each other interpreting each other. Levinas' "ethics first" philosophy (ethics precedes ontology and epistemology) indicates that we have an ethical reflex to respond to other, especially the suffering of other, and from this, we develop a moral compass. If psychotherapy is the art of pickpocketing poorly appreciated existing skills (Socratic maieutics)(Furman & Ahola, 1992), then, this ethical reflex might be brought to awareness for further development by asking: "You are walking home from school on your own, and you need to go to the toilet rather urgently. In fact you are walking funny because of this. You come around the corner, and there lying in the middle of the road is a three year old who has fallen off her tricycle. She is bleeding, and there is no one else about. What do you do?" Alternatively, "How long after you found out the truth about Santa Clause, did you figure out that you needed to protect younger children from this truth?" Both Levinas and Wittgenstein approvingly quote Father Zossima when he says, "everyone of us is responsible for everyone else in every way, and I most of all" (Dostoevsky, 1958, p. 339). The genesis of the enlightened 'self' that Levinas invites us to recognise, is neither the fabricating power/knowledge technologies nor the self-constituting activities Foucault identified, but ethical

calls to 'be for others', especially, when there is more than one call at the same time (the phone and the doorbell ring simultaneously). A 'self' is born as I take a 'position' to manage these multiple calls. The Cartesian-Kantian culture, especially under the extreme individualism of neoliberalism, has blinded me from seeing how much I am called into 'being for others', by encouraging me to punctuate the flow of events as 'being for myself' (Gantt & Williams, 2002).[3] Paradoxically, there is a liberation ('practice of freedom' – Foucault, 1987, p.114) in recognising our responsibility, as Jenkins (1990) showed when working with abusive men.

What Foucault (2011) contributes to this emerging paradigm of a relationally responsive culture lies in the emphasis he gives to the appearance of a particular virtue that can be seen amongst those making this shift. He calls this type of virtue "*parrhēsia*", following the ancient Greeks, where it meant 'fearless speech'. He notes in passing that the Roman physician Galen recognised it as an important characteristic to cultivate as a physician, as physicians needed to cultivate their own ethical authority rather than be subject to external authority. This is perhaps the ethic referred to in Matthew 7.29 where Jesus is referred to as having authority, but not the authority of the Pharisees or scribes. It is perhaps the Taoist virtue of *Te*, which Watts (1977) likens "… to the healing virtues of a plant, having the connotation of power or even magic" (p.107). Following the death of the influential Greek statesman Pericles in 429 BC, Foucault tells us that "… *parrhēsia* and democracy no longer get on so well together" (2010, p.182) and the golden age of Greek politics came to an end.

---

[3] See Mauss (1990) for a 'being for other' cultural economics.

Truth telling gave way to flattery and rhetoric. *Parrhēsiastes* require humility; Foucault shows us that learning is essential in this development of ourselves as a work of art, and error is intrinsic to learning. Risk management systems that punish error do not foster the development of *parrhēsia*, for admission of error has no place in this world of external moral authority. Now Foucault saw the cultivation of this virtue (or what I would call the 'realisation of this virtue') *parrhēsia*, as essential for "… the man [sic] who is responsible for directing others, and particularly for directing them in their effort, their attempt to constitute an appropriate relationship to themselves" (2010, p.43). Thus, it is obviously a highly desirable quality to cultivate in teachers and psychotherapists, but it may take a while for politicians to be candid about their errors. It is best cultivated, Foucault tells us, not through institutional learning, but by being in conversation with someone who has *parrhēsia*. What's more "… he [sic] may be a personal friend, or even a lover" (2011, p.6). Unlike the rhetorician, the *Parrhēsiast* has to open himself to other, even with the risk of violence to oneself (2011, p.11).

The Road to Hell is Paved with Good Intentions

The question being raised in this paper is whether a rule-based mode of risk management, as advanced by formal risk management systems, is at risk of doing harm at multiple levels in our society. This question is being asked in numerous ways. For example, Goodyear-Smith (2012) has raised this question with regards to mandatory reporting of suspected physical, sexual and emotional abuse of children in NZ, and concluded that "the risks outweigh the gains". As

noted previously, Lees and colleagues (2013) identified delays in intervention due to protracted formalised assessments in child protection services in London as leading to deaths. In Britain, Discursive psychology professor Ian Parker suggests that the British Health Council may have become "a machine that incarnates the kind of unhealthy practice it pretends to set itself against" (Haney, 2012). With regards to indigenous health, Ewen (2011) insists that indigenous medical *parrhēsiasts* are needed to challenge the policed "best practice" standards, especially delivery, if the alarmingly poor levels of indigenous health outcomes are to be addressed.

Fischer & Ferlie (2013) describe the closure of Democratic Therapeutic Communities (DTC), which were run across the UK from the 1940s to treat "severe personality disorders", following the implementation of rule-based risk management procedures. It is noteworthy that the alternative for many of these clients is high(er) risk for being "managed" in prisons. DTCs utilised collective treatment through re-socialisation over a 12 month period, where there was "a blurring of roles between staff and residents", and everyone was a 'co-therapist' to everyone else. "Crises are treated as opportunities for remedial exchanges" (p. 36) and thus there was a high degree of tolerance of clinical risk. A crisis would immediately elicit a community meeting, and be resolved through shared decision-making. Staff and residents might take shifts sitting with someone if necessary. But with the rise of the risk management culture in the British NHS, actuarial tables were developed to calculate 'psychopathic risk', detention in secure settings was encouraged, and practitioners were 'named and shamed' should a 'critical incident' occur. The DTC's clinical risk management system, via

building strong relationships of trust, began to give way as a growing distance between staff and resident subcultures occurred. As Rose (1998; Szmukler & Rose, 2013) asserts, the fixation on risk assessment and management is not about treatment but about control, and clients sense this. Shortly after the initiative of turning to the police to handle crises, the DTCs were closed. Fischer & Ferlie conclude that they could find no empirical evidence that a hybridisation between these two modes of risk management could occur in this context. The attempt just heightened the contradiction and contest leading to intractable contest.

Closer to home, the striking off of Nurse Brian Stabb by the NZ Nursing Council in 2005 under rather dubious political circumstances also highlights the conflict between these two modes of risk management. Details of Mr Stabb's case are available on his website (Stabb, 2015a), so only a brief outline is given here. Nurse Stabb had gone to work for the multi-national corporation McKesson (now Medibank) who were piloting, as part of the neoliberal agenda to privatise healthcare, a telephone triage and health advice service (MoH, 2010). Late one night shortly before Christmas, Mr Stabb took a call from a very agitated man with a gun who was threatening homicide and suicide. It turned out that he had a long forensic history, was well-known to the police armed offender squad; and was at the time under a community treatment order which required that he be visited daily by nurses from his DHB to ensure medication compliance and non deterioration. He had not been visited for 48 hours. The crisis team from his DHB could not be contacted by either the police or Mr Stabb's colleagues that night despite the legal requirement for them to be available. In addition, Mr

Stabb's manager, who was also meant to be 'on call', was unavailable. Afterwards, suspicion fell on the above individuals being at a Christmas party together. Mr Stabb alerted the police shortly after the conversation begun, the armed offenders squad was in turn mobilised and the caller's house was surrounded.

About 40 minutes into the conversation, which had been a one-sided tirade of threats to all, including Mr Stabb, Mr Z (as he was subsequently called in Court) said he that was going to hang up and start shooting. The police were imploring Mr Stabb to keep Mr Z on the line. At this point, Mr Stabb let rip with a tirade of his own, saying if the caller made one more threat against him or his family he was going to "…come out there and …stick [his gun] so far up his arse he wouldn't know whether to fart or wind his wrist watch". Mr Z's reaction was to immediately start chuckling and say "Oh sorry mate, there is no need to get uppity". He was now calmed down, and agreed to talk to a counsellor, and gave Mr Stabb his phone number. He said he wasn't going to hurt anyone now, and looked forward to seeing the counsellor. The police negotiator then phoned Mr Z, but Mr Z hung up on him, and phoned Mr Stabb back. They spoke pleasantly for another hour, sharing their experiences in mental health facilities. Mr Z then surrendered to the police. The police sent a complimentary letter to Mr Stabb, thanking him for helping resolve this crisis. A week later Mr Stabb was fired by McKessons, as a complaint had been made by the Crisis team nurses who were meant to have been available, and whose DHB was meant to have been monitoring Mr Z. This went to the Nursing Council, and 18 months later Mr Stabb was struck off.

The complaint alleged Mr Stabb had “issued a threat to a psychiatric patient”. Despite Mr Z’s psychiatrist, police from the armed offenders’ squad, a lawyer who was also a Duly Authorised Officer under the Mental Health Act, all speaking favourably of Mr Stabb’s actions, the Nursing Council claimed that he had not met the high standards nurses must hold themselves to. As Kelly (2012) has asked, are registration boards above the rules of natural justice? Natural justice is “whether reasonable members of the public, informed and with knowledge of all factual circumstances, could reasonably conclude that the reputation and good-standing of the nursing profession was lowered by the behaviour of the nurse concerned” (Gendall, 2000). There appears to have been no consideration of the considerable literature on the difference between a therapeutic boundary-crossing and a boundary-violation, which has been used extensively by some American courts (Guthell & Gabbard, 1993; Zur, 2007). It would appear that Nursing Council, and Justice Wild (2006), who heard and upheld the decision in the High Court when Mr Stabb appealed, relied on the testimonies of the nurses from the crisis team who laid the complaint, and others from the same DHB, to say what the professional standards of nurses in such situations were. Clearly, these nurses had a conflict of interest. Not only that, there was no known investigation of the failure of that DHB to provide crisis coverage that night, no known action was taken against the duty manager of McKesson for his unavailability that night; and McKesson apparently, did not report the breaches of the Act in failing to monitor this patient to the area director of mental health services. As Mr Stabb notes, these are ”very real risks to the public, that are ignored in favour of witch-hunting the professional lowest on the food chain in

this saga" (Stabb 2015b). This case illustrates Power's point (2007), mentioned above, that second-order risk (reputational risks to the profession or organization) is now taking precedence over first-order risk (the safety of the client and others).

Another example of where means are prioritised instead of ends is offered by Prescott (2013), who describes a psychotherapy case with a teen, who had sexually abused his younger cousin. The treatment had been going well, until the State began insisting that the agency provide a particular evidence-based treatment, which the State had contracted with the 'developer' to supply. Like most therapists, the therapist had her own personal supervisor, as well as the consultant employed by the State in this particular evidence-based treatment. The client did not want to explore past traumas in his life at that point in time, but the consultant insisted the therapist push the client to do this, as the evidence-based treatment called for it. At the same time, the therapist's supervisor attempted to support the therapist and the client not to push. After the State director became involved, the client was pushed, and subsequently became withdrawn and asocial. As soon as the evidence-based treatment ended, the client and his family requested a new therapist from a different agency. In this risk adverse environment most practitioners are far more frightened of being blamed by their managers or professional bodies for not adhering to policies and procedures than of bodily harm from their clients (Smith et al, 2003). Mullen and colleagues (2008) report a growth of defensive medicine in NZ mental health due to the fears elicited by these risk management procedures.

As this case illustrates, clinical practice is increasingly being directed by third parties who are highly unlikely to be held accountable should failure occur.

It would appear that a large number of mental health managers are unaware of the large gaps between efficacy and effectiveness (Miller et al, 2013). An efficacy study shows that a particular treatment is effective in a lab trial, but an effectiveness study measures how effective a particular treatment is in a real world clinic. A high number of laboratory studies for psychotherapy show an efficacy rate of 80+%, which is better than many medical treatments. However, 'real world' studies, which are far less common, show a variation in effectiveness, ranging from the 80+% efficacy studies are achieving to a lowly 10% (Kazdin, 2000; Hansen et al., 2002; Weisz, 2004; Lambert, 2010; APA, 2012; Wampold, 2015). This appears to be the cost we are paying for reducing uncertainty by increasing risk assessment (Szmukler and Rose, 2013)[4]. Moreover, there has been a doubling of the number of sickness and invalid beneficiaries due to mental health reasons every decade for 30 years (Whitaker, 2010). The more we attempt to objectify our clients via using actuarial risk assessments (and other assessments), the more the clients sense that they are not being trusted (Porter, 1996). This coupled with a growing sense amongst practitioners that they are not being trusted either and will be held culpable, highlights that the clinic is afflicted with "risk colonization" (Rothstein et al., 2006). This appears to be the best explanation for the poor treatment outcomes. I strongly suspect that those responsible for this 'risk colonization' will not be held to account.

[4] The distinction between risk and uncertainty is not well appreciated in this risk management culture; one is measureable, the other we live with (Szmuckler & Rose, 2013).

The Return of the Jedi

Brunton (2005) has shown that recommendations from public or judicial inquiries into adverse events over the past 100 years have played an important role in major policy changes in the delivery of mental health. During the neoliberal epoch of the late C20th and early C21st, the main points of these recommendations was a greater focus on the responsibility of the practitioner and increasing interventions to manage risk (Le Grand, 2003). Despite the strengthening of accountability processes and increase in risk-management prescribed practices, there appears to be no evidence of enhanced effectiveness or decrease in prevalence of mental health problems (Rosen et al, 2010; MH Commission, 2007; Drury, 2014). Indeed, as we have seen here, such practices have cast a dark shadow over the effectiveness of mental health interventions, decreasing their effectiveness.

At the turn of the millennium a number of mental health practitioners began to take back responsibility for their accountability. Acknowledging the adverse events identified in various public inquiries, these practitioners sought a simpler and more elegant way of increasing accountability. They looked beyond risk management prescribed procedures and a rigorous panopticonian disciplinary gaze upon the practitioner to ensure 'best practice' protocols were being adhered to. They developed a far simpler and more direct way of informing the practitioner that what they were doing was helpful or not; without monitoring by a third party. They developed outcome monitoring tools of various forms

(Bickman, 2008; Duncan et al., 2010; Lambert, 2010). Within a decade of their introduction in 1996, the evidence that these were extremely effective in reducing dropout rates and improving outcomes became overwhelming, and they are now increasingly mandatory in many services (Duncan, 2012; Youn, et al., 2012; Boswell, et al., 2013). Rather than transporting problem specific evidence-based treatments into practice settings, which has had mixed results (Drury, 2014), it is now evident that large public health services that utilise continuous feedback on client outcomes can achieve levels of effectiveness which match those of controlled controlled clinical trials (Reese et al, 2014).

These outcome or progress monitoring tools were growing in popularity at the same time as growing call for increased accountability in health and welfare. The process-focused risk managers responded to this by increasing their monitoring of clinicians and insistence upon the transportation of problem specific evidence-based treatments into practice. However the developers of the outcome monitoring tools and their supporters argued that these new tools facilitated accountability at a much lower cost (Duncan et al., 2010). Utilizing some of these outcome monitoring tools have been accepted as evidence-based practice in its own right, no matter what other structures (e.g. ESTs) might also be preferred by the therapist and client (Duncan, 2012, 2013; Miller et al, 2013). Despite Justice Wild's (2006) claim in the Nurse Stabb case that practitioners should be judged on process and not outcome, those in the outcome monitoring camp argue that accountability must at least include outcome (Garralda, 2009; Nordal, 2012). In welfare, this shift is called 'results-oriented accountability' (ROA) (McDonald & Testa, 2010). Even the American Psychological Association

has joined in, suggesting that the 'Physician Quality Reporting System' in the US should become more outcome based for psychologists (Nordal, 2012). After all, if outcome is good, should the process be emphasized, let alone prioritized? In the US, the National Quality Forum on health is now calling for 'Patient-reported outcomes' (PROs) to be used across all health systems, which they define as "any report of the status of a patient's health condition, health behaviour, or experience with healthcare that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else" (National Quality Forum, 2013, p. 5). [5]

Some of the continuous outcome monitoring management systems provide feedback data to practitioners on their comparative effectiveness with other practitioners (Bickman, 2008). These practitioners are now better positioned "to help the public make informed choices of the quality and type of service provided" (s.3.1.2, NZ Psychological Society 2002). Sparks and colleagues (2011) indicate that by incorporating outcome monitoring tools into the training programmes of family therapists, the trainees not only developed a far greater sense of their accountability to their clients, but for most, their clients became their primary teachers. This may help facilitate the shift from the monological to the dialogic (Bakhtin, 1986), where the other is no longer an object of consciousness, but "a consciousness". Alternatively, in the Freire (1996) sense of a shift from the 'banking' system of education, where teachers anaesthetise students to fill them with facts (which is duplicated in the therapy clinic), to a

[5] This definition suggests NZ's MoH preference for the HoNOS suite would not be favoured by the NQF.

more active and aesthetic divergent model which encourages experimentation and allows for error in order for learning to occur (Wilson, 2015). Indeed, judging by the growing number of “coaches” who utilize continuous outcome monitoring management advertising their wares on the internet and elsewhere, a new class of therapists emerged who have left the confines of the risk management culture and their educational systems that the guilds have become ensnared in.

The reluctance by some psychologists to incorporate outcome management systems into their work may stem from concerns as to how they will be treated should they admit error, or discover that they are not in the top half of the bell-curve for practitioner effectiveness. An invitation is made to the disciplinary bodies to become outcome focused as well. Instead of focusing on separating the ‘knights’ from the ‘knaves’ (Le Grand, 2003) (which just seems to drive the ‘knaves’ to the handle end of the punishment stick), they might protect the public better by identifying those clinics that are getting ‘effectiveness’ rates well below the 80% efficacy rate. Instead of seeking advice from educationalists teaching particular empirically supported treatments so that anaesthetic education continues, they might turn to those for advice who are achieving high levels of effectiveness. Many of these *parrhēsiastes* (supershrinks) may not be easily identified other than from their measured outcomes. Okiishi and colleagues (2003) found supervisors and colleagues couldn’t tell the ineffective and highly effective therapists apart. Najavits and Strupp (1994) showed that effective clinicians were making more mistakes and were more self-critical.

Such a shift would be consistent with Argyris' (2004) call for 'double-loop learning' in organizations (which also finds expression in Senge's learning organisations (2006)). Argyris' 'double-loop learning' offers great hope for the ecological movement, as the openness of an organisation to allow its core values to change facilitates a shift requisite for an organization to become a more responsive global citizen. For example, when the C19th railway companies remained focused on trains rather than transport, they did not fare so well in the C20th. When one looks at many of the adverse events that called the professional disciplinary bodies into existence, had there been more sensitive feedback loops on outcomes to the practitioners, might we have witnessed a different history? Miller and colleagues (2013) suggest that with the advent of outcome management systems we now need supportive "communities of practice" rather than further risk-adverse systems that are impeding this shift to greater effectiveness.

Conclusion

In the 1930s, Wittgenstein commented that he was writing for people 100 years from then, when culture might be returning. He thought that it had been gradually disappearing beneath the mechanical machine. This paper outlined the manifestations of the risk-adverse discourse, and how it has brazenly discouraged more enlightened people to point out that "the emperor has no clothes" and guide others into a more responsible and responsive way of being. The shift from a Cartesian-Kantian mechanical culture to a Wittgensteinian-Levinasian one will require Jedis.

REFERENCES

American Psychological Association (2012, August 9). *Resolution on the recognition of psychotherapy effectiveness*. American Psychological Association. Retrieved from http://www.apa.org/about/policy/resolution-psychotherapy.aspx

Anderson, R., & Wong, J. (2013). Truth and the 'politics of ourselves'. *The Southern Journal of Philosophy, 51* (4), 419-444.

Argyris, C. (2004). *Reasons and rationalizations: the limits to organizational knowledge.* New York: Oxford University Press.

Aristotle, & Kenny, A. (2013). *Poetics*. Oxford: Oxford University Press.

Bakhtin, M.M. (1986). *Speech genres and other late essays*. Trans. By V.W. McGee. Austin, TX: University of Texas Press.

Beck, U. (1999). *World Risk Society*. Cambridge: Polity Press.

Bickman, L. (2008). A measurement feedback system (MFS) is necessary to improve mental health outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry, 47* (10), 1114-1119.

Boswell, J.F., Kraus, D.R., Miller, S.D. & Lambert, M.J. (2013) Implementing routine outcome monitoring in clinical practice: benefits, challenges, and solutions. *Psychotherapy Research, 25* (1), 6-19.

Brunton, W. (2005). The place of public inquiries in shaping New Zealand's mental health policy 1858-1996. *Australia and New Zealand Health Policy, 2*, 24-40.

Chemero, D. (2009). *Radical Embodied Cognitive Science*. Cambridge, MA: MIT Press.

Chiappelli, F., Brant, X.M.C., & Cajulis, C.B. (Eds.) (2012). *Comparative effectiveness and efficacy research and analysis for practice (CEERAP).* New York: Springer.

Cooper, M. (2011). Meeting the demand for evidence-based practice. *Therapy Today, 22*, 4: 10-16.

Deacon, R.A. (2003). *Fabricating Foucault: Rationalising the management of individuals*. Milwaukee, WI: Marquette University Press.

Dostoevsky, F. (1958). *The Brothers Karamazov.* Trans. D. Magarshack. Middlesex: Penguin.

Drury, N., & Munro, T.A. (2008). Crisis engagement in mental health: A New Zealand Māori contribution. *International Journal of Mental Health Nursing, 17* (5), 317-325.

Drury, N. (2011). Wittgenstein and the tikanga of psychotherapy. *NZ Journal of Psychology, 40* (2), 16-24.

Drury, N. (2013). Wittgenstein and the red queen: attuning to the world and each other. *NZ Journal of Psychology, 42* (3), 18-26.

Drury, N. (2014). Mental health is an abominable mess: mind and nature is a necessary unity. *NZ Journal of Psychology, 43* (1), 5-17.

Drury, N. (2015). A taste of Wittgenstein for SFBT. 2: Philosophical Investigations. *Journal of Solution-Focused Brief Therapy, 1* (2), 1-18.

Duncan, B.L., Miller, S.D., Wampold, B.E., & Hubble, M.A. (Eds.) (2010) *The Heart and Soul of Change, 2nd Edition: Delivering What Works in Therapy*. Washington, DC: American Psychological Association.

Duncan, B.L. (2012). The partners for change outcome management systems (PCOMS): The heart and soul of change project. *Canadian Psychology, 53* (2), 93-104.

Duncan, B.L. (2013). PCOMS Now a SAMHSA evidence based practice. Blog retrieved from: https://heartandsoulofchange.com/content/resources/viewer.php?resource=news&id=21

Easton, B. (2002). The New Zealand reforms of the 1990s in context. *Applied Health Economics and Health Policy, 1* (2), 93-115.

Ewen, S.C. (2011). Unequal treatment: The possibilities of and need for indigenous parrhesiastes in Australian medical education. *Journal of Immigrant and Minority Health, 13* (3), 609-615.

Fischer, M.D. & Ferlie, E. (2013). Resisting hybridisation between modes of clinical risk management: Contradiction, contest, and the production of intractable conflict. *Accounting, Organizations and Society, 38* (1), 30-49.

Foucault, M. (1984). What is Enlightenment? In P. Rabinow (ed.,) *The Foucault Reader*. New York: Pantheon. Pp. 32-50.

Foucault, M. (1985). *The use of pleasure. The history of sexuality, Volume 2.* (R. Hurley, Trans.) New York: Vintage Books.

Foucault, M. (1987). The ethic of care for the self as a practice of freedom: An interview with Michael Foucault on January 20, 1984. *Philosophy & Social Criticism, 12* (2-3), 112-131.

Foucault, M. (1986). *The care of the self. The history of sexuality, Volume 3.* (R. Hurley, Trans.) New York: Pantheon Books.

Foucault, M. (1997). *The Politics of Truth*. New York: Semiotext(e).

Foucault, M. (2005). *The hermeneutics of the subject: Lectures at the Collège de France 1981-1982.* New York: Palgrave Macmillan.

Foucault, . (2006). *Psychiatric Power: Lectures at the the Collège de France, 1973-1974.* Basingstoke, Hampshire: Palgrave Macmillan.

Foucault, M. (2008). *The Birth of Biopolitics: Lectures at the the Collège de France, 1978-1979.* Basingstoke, Hampshire: Palgrave Macmillan.

Foucault, M. (2010). *The government of self and others: Lectures at the Collège de France 1982-1983.* Basingstoke: Palgrave Macmillan.

Foucault, M. (2011).). *The courage of truth (the government of self and others II): Lectures at the Collège de France 1983-1984.* Basingstoke: Palgrave Macmillan.

Freire, P. (1996) *Pedagogy of the oppressed*. London: Penguin Books.

Furman, B., & Ahola, T. (1992). *Pickpockets on a nudist camp: the systemic revolution in psychotherapy.* Adelaide: Dulwich Centre Publications.

Gantt, E.E. & Williams, R.N. (2002). *Psychology for the Other: Levinas, Ethics, and the Practice of Psychology*. Pittsburgh: Duquesne University Press.

Garralda, E.M. (2009). Accountability of specialist child and adolescent mental health services. *British Journal of Psychiatry, 194* (5), 389-391.

Gendall, Justice. (2004). *Collie v Nursing Council of New Zealand*. HC, Wellington AP 300/99, 5 September 2000.

Goodyear-Smith, F. (2012). Should New Zealand introduce mandatory reporting by general practitioners of suspected child abuse? No. *Journal of Primary Health Care, 4* (1), 77-79.

Gutheil, T.G., & Gabbard, G.O. (1993). The concept of boundaries in clinical practice: Theoretical risk-management. *American Journal of Psychiatry, 150* (2), 180-196.

Habermas, J. (1987). *The Philosophical Discourse of Modernity*. Cambridge, MA: MIT Press.

Haney, J. (2012). *Regulation in Action: The Health Professions Council Fitness to Practice Hearing of Dr Malcolm Cross – Analysis, History, and Comment*. London: Karnac.

Hansen, N.B., Lambert, M.J., & Forman, E.M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9* (3), 329-343.

Harding, D. E. (1961). *On having no head: a contribution to Zen in the West*. London: The Buddhist Society.

Harvey, D. (2007). *A Brief History of Neoliberalism.* Oxford: Oxford University Press.

Hutto, D. (2012). Radically enactive cognition in our grasp. In Z. Radman (ed.) *The Hand: an organ of the mind*. Cambridge, MA: MIT Press.

Jenkins, A. (1990). *Invitations to responsibility: the therapeutic engagement of men who are violent and abusive*. Adelaide: Dulwich Centre Publications.

Kant, I. (1784/1996). An answer to the question: What is enlightenment? In M. J. Gregor (Ed.) *Practical Philosophy*. Cambridge UK: Cambridge University Press.

Kazdin, A.E. (2000). *Psychotherapy for children and adolescents: Directions for research and practice*. New York: Oxford University Press.

Kelly, M. (2012). Challenging the powers that be: Are registration boards above the rules of natural justice? Auckland, APEX and NZ Medical Laboratory Workers. Downloaded January 17th 2015 from: www.nzmlwu.org.nz/wp-content/uploads/2012/04/Regsitration-Boards.pdf [NB: 'registration' misspelt]

Lambert, M.J. (2010). *Prevention of Treatment Failure: The use of measuring, monitoring, and feedback in clinical practice*. Washington, DC: APA Press.

Laska, K.M. & Wampold, B.E. (2014). Ten things to remember about common factor theory. *Psychotherapy, 51* (4), 519-524.

Lees, A., Meyer, E., & Rafferty, J. (2013). From Menzies Lyth to Munro: The Problem of Managerialism. *British Journal of Social Work. 43* (3), 542-558.

Le Grand, J. (2003). *Motivation, agency and public policy: Of knights and knaves, pawns and queens*. Oxford: Oxford University Press.

Levinas, E. (1998). *Otherwise than Being, or, Beyond Essence.* Trans. A. Lingis. Pittsburgh: Duquesne University Press.

Lok Wing-Kai, P. (2011). *Foucault, Levinas and the ethical embodied subject*. Doctoral Thesis. Vrije Universiteit Amsterdam. http://hdl.handle.net/1871/19961

McDonald, T, & Testa, M.F. (2010). Outcomes Monitoring in Child Welfare. In M.F. Testa & J. Poertner (Eds.) *Fostering Accountability*, pp. 101-135. Oxford: Oxford University Press.

Mauss, M. (1990). *The gift: The form and reason for exchange in archaic societies.* Trans. W.D Halls. London: Routledge.

Mental Health Commission. (2007). *Te Haererenga mot e Whakaōranga 1996-206: The journey of recovery for the New Zealand mental health sector.* Retrieved from: http://www.hdc.org.nz/media/199550/te_haererenga%20%201996-2006.pdf

Menzies Lyth, I. (1988). The functioning of social systems as a defence against anxiety. In I. Menzies Lyth (ed.), *Containing Anxiety in Institutions (Selected Essays Volume 1).* London: Free Association Books.

Milchman, A., & Rosenberg, A. (2007). The aesthetic and ascetic dimensions of an ethics of self-fashioning: Nietzsche and Foucault. *Parrhesia, 2*, 44-65.

Miller, S.D., Hubble, M.A., Chow, D.L. & Seidel, J.A. (2013). The outcome of psychotherapy: yesterday, today, and tomorrow. *Psychotherapy, 50* (1), 88-97.

Ministry of Health. (2010). McKesson. *Healthline News*. June 2010, 5.

Mullen, P. (2000). Dangerousness, risk, and the prediction of probability. In, M. Gelder, J. Lopez-Ibor & N. Andreasen (Eds.) *New Oxford Textbook of Psychiatry, Volume 2*, (pp. 2066-2078). Oxford: Oxford University Press.

Mullen, R., Admiral, A., & Trevena, J. 2008). Defensive practice in mental health. *New Zealand Medical Journal, 121*, 85-91.

Najavits, L., & Strupp, H. (1994). Differences in the effectiveness of psychodynamic therapies: A process-outcome study. *Psychotherapy, 31* (1), 114-123.

National Quality Forum (2013). *Patient Reported Outcomes (PROs) in Performance Measurement.* Washington, DC: National Quality Forum.

New Zealand Psychological Society (2002). *Code of Ethics: For psychologists working in Aotearoa/New Zealand*. N.Z. Psychological Society.

Noë, A. (2009). *Out of Our Heads: Why you are not your brain, and other lessons from the biology of consciousness*. New York: Hill and Wang.

Norcross, J.C. (2011) *Psychotherapy relationships that work: Evidence-based responsiveness, 2nd ed.* New York: Oxford University Press.

Nordal, K.C. (2012). Outcome measurement benefits psychology. *APA, Perspectives on Practice, 43* (1), 51.

Ogloff, J. (2006). The violent client: Advances in violence risk management. Paper presented to the Australian Psychological Society, Melbourne. Retrieved Feb 20 2015 from: http://www.psychology.org.au/publications/inpsych/risk/

Okiishi, J., Lambert, M., Neilsen, S., & Ogles, B. (2003). Waiting for the supershrink: an empirical analysis of therapist effects. J*ournal of Clinical Psychology and Psychotherapy, 10* (6), 361-373.

O'Malley, P. (2004). *Risk, Uncertainty, and Government*. London: Glasshouse Press.

Overgaard, S. (2007). *Wittgenstein and Other Minds: Rethinking subjectivity and intersubjectivity with Wittgenstein, Levinas, and Husserl*. New York: Routledge.

Porter, T. (1996). *Trust in numbers: The invention of objectivity*. Princeton: Princeton University Press.

Power, M. (2004). *The risk management of everything: Rethinking the politics of uncertainty.* London: Demos.

Power, M. (2007). *Organized uncertainty: Designing a world of risk management.* Oxford: Oxford University Press.

Prescott, D.S. (2013). The Rashomon dilemma: perspectives on and dilemmas in evidence-based practice. *International Journal of Behavioral Consultation and Therapy, 8* (3-4), 43-48.

Reese, R.J., Duncan, B., Bohanske, R., Owen, J., & Minami, T. (2014). Benchmarking outcomes in a public behavioral setting: Feedback as a quality improvement strategy. *Journal of Consulting & Clinical Psychology, 82* (4), 731-742.

Rose, N. (1998). Governing risky individuals: The role of psychiatry in new regimes of control. *Psychiatry, Psychology and Law, 5* (2), 177-195.

Rosen, A., Goldbloom, D., & McGeorge, P. (2010). Mental Health Commissions: Making the critical difference to the development and reform of mental health services. *Current Opinion in Psychiatry, 23* (6), 593-603.

Rothstein, H., Huber, M., & Gaskell, G. (2006). A theory of risk colonization: The spiralling regulatory logics of societal and institutional risk. *Economy and Society, 35*, 91-112.

Senge, P.M. (2006). *The fifth discipline: the art and practice of the learning organization.* New York: Doubleday.

Smith, M., McMahon, L. & Nursten, J. (2003). Social workers' experience of fear. *British Journal of Social Work, 33* (5), 659-680.

Sparks, J.A., Kisler, T.S., Adams, J.F., & Blumen, D.G. (2011) Teaching accountability: Using client feedback to train effective family therapists. *Journal of Marital & Family Therapy, 37* (4), 452-467.

Stabb, B. (2015a). www.brianstabb.net

Stabb, B. (2015b). The Lois Lane Interviews. https://drive.google.com/file/d/0B_MkfjQPUFEdeGhjM0ppN2I0VGs/view?pli=1

Strawson, G. (2004). Against narrativity. *Ratio, 17* (4), 428-452.

Suzuki, D.T. (1949). *The Zen Doctrine of No-Mind*. London: Rider & Company.

Szmukler, G., & Rose, N. (2013). Risk assessment in mental health care: values and costs. *Behavioral Sciences and the Law, 31* (1), 125-140.

Wampold, B.E., & Imel, Z.E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work. 2nd ed*. New York: Routledge.

Ward, S.C. (2011). The machinations of managerialism: New Public management and the diminishing power of professionals. *Journal of Cultural Economy, 4* (2), 205-215. Doi: 10.1080/17530350.2011.563072

Watts, A.W. (1977). *Tao: The watercourse way.* New York: Pantheon.

Weisz, J.R. (2004). *Psychotherapy for children and adolescents: Evidence-based treatment examples.* Cambridge: Cambridge University Press.

Whitaker, R. (2010). *Anatomy of an epidemic: magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Crown.

Wild, J. (2006). *Stabb v Preliminary Proceedings Committee*. HC Wellington, 2 October 2006, CIV 2006-485-1317.

Wilson, J. (2015). Family therapy as a process of humanisation: The contribution and creativity of dialogism. *Australian and New Zealand Journal of Family Therapy, 36* (1), 6-19.

Wittgenstein, L. (1958). *Philosophical Investigations (2nd edition)*. Oxford: Blackwell.

Youn, S.J., Kraus, D.R., & Castonguay, L.G. (2012). The treatment outcome package: Facilitating practice and clinically relevant research. *Psychotherapy, 49* (2), 115-122.

Zur, O. (2007). *Boundaries in Psychotherapy: Ethical and Clinical Explorations*. Washington, DC: American Psychological Association.