Commentary: On action guidance and good practice in early intervention for psychosis. A response to Bortolotti & Jefferson (2018)

Authors

1st author: Paolo Corsico (corresponding author).

Main affiliation: Centre for Social Ethics and Policy, School of Law, the University of Manchester.

Second affiliation: Department of Psychiatry, University of Oxford.

Address: School of Law, Williamson Building, the University of Manchester, M13 9PL Manchester, United Kingdom.

Email: paolo.corsico@postgrad.manchester.ac.uk

2nd author: Ilina Singh.

Affiliation: Department of Psychiatry and Wellcome Centre for Ethics and Humanities, University of Oxford.

Address: University Department of Psychiatry, Warneford Hospital, OX3 7JX Oxford, United Kingdom.

Email: ilina.singh@psych.ox.ac.uk

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Abstract

In this response to Bortolotti and Jefferson (2018), we discuss the action-guidance problem of moral attributes and the risk of superiority illusion in early intervention for psychosis. First, we suggest that guidance documents are not devoid of behavioural recommendations and goals for service provision, though these are not linked to the ethical dimensions of good practice embedded in the documents. Second, we acknowledge the risk of superiority illusion; we suggest that this risk may be reduced if the ethical and clinical goals of early intervention are presented as interrelated and measurable.

Introduction

In their thoughtful commentary 'What aspects of good practice in early interventions in psychosis can be codified in guidelines? A reflection on Corsico et al. (2017)', Lisa Bortolotti and Anneli Jefferson highlight two areas of concern in our attempt to investigate the ethical dimensions of good practice in Early Intervention (EI) for psychosis. First, the authors point out that simply presenting professionals working in EI with a number of moral attributes that they should cultivate, such as *competency, empathy, sensitivity, and trustworthiness*, might not be an effective way to promote good practice. The commentary authors argue that such concepts are not *specific* enough that they can provide effective action guidance. Second, the authors warn against the risk that, if presented with a series of moral attributes, professionals may believe that they already possess those attributes, when in reality they do not, or they possess them only minimally. This is known as the 'better-than-average effect', or superiority illusion (Brown, 2012). Thus, "including an explicit reference to moral attributes in EIP guidelines will not lead service providers to act more ethically" (cit.). To avoid these two problems Bortolotti and Jefferson suggest that any reference to moral attributes in EI guidance should be supplemented by: i) behavioural recommendations and examples, and ii) specific goals for EI service provision.

Action guidance and ethical touchpoints of good practice

Bortolotti and Jefferson highlight relevant concerns; we can refer to the two problems identified above as: a) the action-guidance problem of moral attributes; and b) the superiority illusion.

Let us focus on the action-guidance problem. Bortolotti and Jefferson point out that competency, empathy, sensitivity, and trustworthiness are not normally considered to be moral attributes; rather, they are positive features of agents that can support moral agency. This is certainly true; we accept our commentators' specification. Yet, are these moral attributes or positive features *under-specified*? Bortolotti and Jefferson view the problem of under-specification in the context of a lack of action guidance and argue that that moral attributes in EI guidance should be supplemented by i) behavioural recommendations and examples; and ii) specific goals for EI service provision.

First, it is worth noting that the clinical guidance documents we analysed contained behavioural recommendations and examples. Indeed, our analysis proceeded by asking what kinds of moral attributes were implicit in the behavioural recommendations provided. For example, take the moral attribute 'empathy'. As we show in our analytic breakdown, we developed this attribute by collapsing three themes coded in the data: 'provide support', 'foster autonomy', and 'giving hope / being positive'. The theme of 'giving hope / being positive' was mentioned in six documents. For instance, it was phrased in the following terms: "Provide treatment and care in the least restrictive and stigmatising environment possible and in an atmosphere of hope and optimism […]" (CG178, p. 27); or "provide information, support, and guidance to maintain hope and optimize coping" (IRIS, p. 18). It is true that such behavioural recommendations contain moral concepts, such as *hope* and *autonomy*, which may not be fully specified. But the clinical guidance documents are not devoid of operational specifications, even though these are not comprehensive.

Second, the guidance documents contain already a number of specific goals for EI service provision. Let us refer to one specific goal mentioned by Bortolotti and Jefferson: avoid prescribing medications to users where possible. This goal of EI service provision is explicitly stated within the guidelines we analysed. Particularly, the guidelines are straightforward in recommending offering

antipsychotic medications only to individuals who have already experienced a first episode of psychosis, and not to individuals who are at risk of developing psychosis. For instance, this point is made explicit in CG155, p. 8, "Do not offer antipsychotic medication: for psychotic symptoms or mental state changes that are not sufficient for a diagnosis of psychosis or schizophrenia; or with the aim of decreasing the risk of psychosis."

We believe that what is missing in EI guidance documents is an *explicit* reference to the ethical and moral touchpoints that inform good practice in EI and, more importantly, an explicit *link* between ethical requirements of service delivery, moral attributes of clinicians, and the behavioural recommendations provided.

Superiority illusion and guideline revision

The second concern expressed by Bortolotti & Jefferson is the superiority illusion. We acknowledge that this is a risk in EI professionals. However, when the moral attributes of EI professionals are made explicit and linked with substantive behavioural recommendations that are in turn tied to specific goals of practice, it will be more difficult to suffer from a superiority illusion. In other words, we would expect that when EI professionals are aware that the ethical and clinical goals of EI services are both interrelated and measurable, the risk of superiority illusion is reduced.

There is one last clarification we should note. The primary aim of our analysis was not to provide ethical grounds for the revision of clinical guidelines. Rather, our analysis aimed to investigate the ethical touchpoints of good practice in EI for psychosis, as they are expressed within a corpus of clinical guidelines published in England. By so doing, we believe that we have provided a useful dimension for the eventual evaluation of EIP services; specifically with regard to the criteria for 'good practice.' This evaluation may result in guideline revision; or its results may take other forms; e.g. EI service redesign, or implementation of ethics education for EI service providers. EI services are challenging in no small part because the target problems, the path to a good outcome, and the definition of 'good outcome' are less defined than in standard diagnostic clinical services. As

such, there is an onus on EI practitioners to act well in a space of ambiguity. We hope that our analysis empowers EI practitioners to understand that 'good practice' is more than adherence to rules and duties; it is also tied to an ability and desire to continually modify clinical actions in ways that respond sensitively to the client and foster a co-produced vision for flourishing.

Conclusions

Will including an explicit reference to moral attributes in EI guidelines lead service providers to act more ethically? We do not know. This is primarily an empirical question, which ought to be answered with empirical methods. As Bortolotti and Jefferson have effectively pointed out, there is a risk that ethical recommendations might become empty, and professionals suffer from superiority illusion, if recommendations are not framed within clear and specific goals for good practice. At the same time, we believe that making ethical requirements and desirable moral attributes explicit to professionals working in EI may positively impact on how such professionals enact the recommendations provided in guidance documents. Reflecting on the ethical and moral touchpoints of good practice may thus be a step towards a better delivery of EI for psychosis.

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References

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