Editorial

Rachel Perkins and Julie Repper

Rachel Perkins is Independent Consultant and Trainer at London, UK. Julie Repper is based at the Nottingham Recovery Centre, Nottingham, UK.

Reclaiming recovery

The concept of recovery is not without its critics, and increasingly we hear people questioning whether we should continue to use the term "recovery".

Such debates are not new. Mary O'Hagan (2002) describes the debates among mental health service users in the late 1990s about whether to use the term: "We nearly didn't adopt "recovery" [. . .] if we had been able to agree on another word we would have jumped on it" (O'Hagan, 2002, p. 16). The objections?

- Recovery as "cure" "I'll always have mental health problems so I'll never recover"
- Recovery as "going back to how things were before": "Recovery takes you back to where you were, but my experience has transformed me".
- Recovery as "recovery from an illness": "I don't believe I had an illness but recovery implies that I have one". "I don't think madness is undesirable, so what do I need to recover from?"
- Recovery as "denial of mental health challenges": "To recover means to cover up again, but I don't want to cover up my distress".

(All quotes from O'Hagan, 2002, p. 16)

More importantly, some concerns expressed were more fundamental:

> [. . .] first, that recovery is an import from America; second, the Americans, in emphasising recovery as an individual process, have seemed to overlook it as a social process as well; and third, that recovery in America evolved out of psychiatric rehabilitation and was perhaps more driven by professionals than by service users (O'Hagan, 2002, p. 16).

At the moment, in the UK, some similar criticisms are being made by. For example, by "Recovery in the Bin": a user-led group for psychiatric survivors and supporters who are "fed up with the way co-opted "recovery" is being used to discipline and control those who are trying to find a place in the world, to live as they wish, while trying to deal with the very real mental distress they encounter on a daily basis" [1]. They argue that an approach that started with "noble principles" has been co-opted by psychiatric services and "neoliberal ideology and now mostly operates as a cover for coercion, victim blaming, denial of disability and removal of services" [1].

In its original conception, people living with mental health challenges clearly said that recovery is not about "getting better" but getting a life you value (see, for example, Chamberlin, 1988; Deegan, 1988; Leete, 1989): in New Zealand, it was defined as "living well in the presence or absence of one's mental illness" (O'Hagan, 2002, p. 1). Neither did these original conceptions talk about "going back to how things were before. Patricia Deegan (1988) talked about how people "[. . .] experience themselves as recovering a new sense of self and of purpose within and beyond the limits of disability" (p. 1, emphasis added), and Bill Anthony(1993) describes recovery as involving "[. . .] the development of a new meaning and

purpose in life as one grows beyond the catastrophic effects of mental illness" (p. 17, emphasis added).

We, like Mary O'Hagan (2002), have argued in the pages of *MHSI* that recovery has to be seen within the context of the individual's family, social network, community and culture too often *[. . .] the social, political and economic context of recovery and all the discrimination and oppression that people face are minimised and ignored* (Perkins and Repper, 2018, p. 161). Similar to Recovery in the Bin [2], we have argued that there is a need for a social model of distress and mental health challenges based on thinking within the broader disability movement that has long recognised that a clinical model is of little value in enabling people to live well as part of communities.

> It is attitudes, actions and assumptions – social, cultural and physical structures which disable by erecting barriers and imposing restrictions and limiting options [. . .] The social model of disability is about nothing more complicated than a clear focus on the economic, environmental and cultural barriers encountered by people who are viewed by others as having some form of impairment [. . .] (Oliver, 2004, p. 6).

However, such as O'Hagan (2002), we would see a social model as central to the concept of recovery (Perkins, 2012, 2015; Perkins and Repper, 2018): the need for a move away from a "clinical" model directed towards helping people to "fit on" (by treating symptoms and remedying the person's deficits) but changing the world so that it can accommodate all if us. Indeed, as far back as 1992, Patricia Deegan in her early conceptualisations of recovery makes a similar point:

> For most of us, mental health problems are a given [. . .] the real problems exist in the form of barriers in the environment that prevent us from living, working and learning in environments of our choice [the task is] to confront, challenge and change those barriers and to make environments accessible [. . .] environments are not just physical places but also social and interpersonal environments [. . .] those of us with psychiatric disabilities face many environmental barriers that impede and thwart our efforts to live independently and gain control over our lives (Deegan, 1992, p. 11).

We would suggest that most of the objections to the concept of recovery arise because, in the words of Recovery in the Bin, "[. . .] the concept of 'recovery" has been co-opted by mental health services, commissioners and policy makers" [3] and that the power of the prevailing mental health system has distorted the concept. Although some English authors, those with lived experience of mental health challenges, have described recovery as the journey of an individual as they grow within and beyond what has happened, (see, for example, Coleman, 1999; Reeves, 1998; Repper and Perkins 2003), for the most part.

> in England, ideas about recovery in mental health services have been driven by professionals and policy makers [. . .] and transformed from the journey of an individual to a model of service provision (Perkins and Slade, 2012, p. 29).

We have seen the emergence of "Recovery Teams" and "Recovery Workers", not to mention "Recovery Interventions" such as the Recovery Star (McKeith *et al.*, 2010). This prescribes the dimensions of recovery (living skills, addictive behaviour, managing mental health, etc.), the nature of "progress" on a ten-step ladder from "stuck" to "self-reliance", all a long way from the "deeply personal, unique process" (p. 15) of which Anthony(1993) spoke. As Deegan(1988) said "[. . .] people are, above all, individuals and will find their own special formula for what promotes their recovery and what does not" (p. 4).

As mental health professionals and services have taken over the concept of recovery, they have imposed upon it the essentially clinical approach of changing the individual: putting right that which has gone wrong. The material and social realities of, for example, the poverty, poor housing, unemployment, social isolation, racism, discrimination and exclusion that are the daily reality for so many people who experience mental health challenges receive far less

attention. “Success” is defined, if not in terms of “cure”, then in terms of people becoming independent and leaving services. Responsibility for recovery or “failure to recover” is laid firmly in the hands of the individual; if they fail to achieve the independence or “self-reliance”, which is the goal of the Recovery Star, then they must “lack the motivation to recover”. As Deegan(1988) says, services based on neoliberal values of individual achievement, independence and self-sufficiency are oppressive for many people. In their original conception, recovery, inclusion and citizenship “[. . .] are not about ‘becoming normal’ but creating inclusive communities that can accommodate all of us. Not about ‘becoming independent’ but having the right to support and adjustments (in line with our choices and aspirations) to ensure full and equal participation” (Slade *et al.*, 2014, p. 14). Such rights are enshrined in the United Nations Convention on the Rights of Persons with Disabilities, which, thanks to the efforts of many service user/survivor activists, includes people living with mental health challenges.

As mental health professionals and services have taken ownership of the “recovery”, the history of the recovery movement has been re-written. The origins of “the recovery movement” are sought in mental health services. For example, Davidson *et al.*(2010) attribute its origins to the work or psychiatric reformers such as Pinel and the establishment of the “York Retreat” in 1796, as do the Care Services Improvement Partnership, Royal College of Psychiatrists and Social Care Institute for Excellence(2007) in their Joint Position Statement. To be sure, the birth of “humanitarian psychiatry” represented progress with its desire to replace the chains, shackles, intimidation and neglect of the traditional “mad house” with respect, friendship and kindness (Tuke, 1813). However, it remains a professional intervention: something that services do to put right that which has supposedly gone wrong. It redefines recovery in terms of mental health services rather than the experience, analysis and writing of people with mental health challenges.

So has the concept of “recovery” had its day? Or in the words of O’Hagan (2002) “Were we right to go with the term ‘recovery’?” (p. 1).

Her conclusion is that they were right, but only if we clearly define recovery and pass ownership of recovery to people who experience mental health challenges. We would agree. Any concept can be co-opted and corrupted, and perhaps because of the threat that it poses to the established order, this is most likely to happen when a concept arises not from expert professional theories but from the expertise of lived experience. To abandon the concept in the face of such co-option would be to abandon the wisdom of lived experience on which it was founded.

We would argue that it is better to reclaim the concept.

Recovery is the experience of, and owned by, people living with mental health challenges (or facing other life changing events): “A journey in which professionals, and the services they inhabit, are not at centre stage, but may (or may not) have a marginal, supporting, role” (Perkins and Slade, 2012, p. 29). Recovery is not an “intervention” or something that services do – the question for services is whether they support or hinder the individual’s journey.

Recovery may be an individual journey, but it is not a journey travelled alone or in a vacuum. Individuals live and grow, and can only be understood within, the context of a families and social networks, communities and cultures. This impacts on the meaning of the experience and the possibilities open to a person, as do their social and economic circumstances; the impact of discrimination and disadvantage must never be underestimated and must always be addressed. The essence of the concept is not on of “recovering from an illness” or “getting better” but of “recovering a life” and “living well” in terms defined by the individual, not those who purport to help them. It is not about “self-sufficiency” and “independence” but the right to the support and adjustments you need to live well and do the things you value: creating inclusive communities that enable everyone to participate and contribute.

Most of all, reclaiming recovery requires that we reformulate the role and position of mental health services.

> The most challenging decisions ahead are not how to increase access to professional services but how to maximise life chances and enable people with mental health conditions to make the most of their lives. The real challenge is how to do things differently and use resources differently: recognise the limitations of traditional professional expertise, the value of the expertise of lived experience and rekindle the belief that citizens hold most of the solutions to human problems' (Perkins, 2010, p. 36).

O'Hagan(2018) has argued that "A health-led system will not deliver the fundamental changes needed – psychiatry needs to move from the hub of the system to being one of the spokes in a multi-sector community-led system" [4].

Figure 1 From Big Psychiatry to Big Community

Notes: From O'Hagan, 2018, p. 6. Whānau is the Māori word meaning extended family. Historically a collective of people with a common ancestor, in the modern context, it may also include friends who may not have kinship ties and others bound together by a common cause or interest (e.g. a group of friends, church, support group, team mates and colleagues). Whānau recognises that each member is supported by other members

She, too, goes on to argue that "Big Community needs to replace Big Psychiatry at the hub of the system and position psychiatry as one of its many spokes, so that everyone with mental distress [. . .] has open access to a comprehensive range of responses" (O'Hagan, 2018, p. 3; Figure 1).

Notes

1. Recovery in the Bin Key Principles, page 1, https://recoveryinthebin.org/ritbkeyprinciples/ Accessed 12th January 2021.
2. Recovery in the Bin Key Principles, page 1, https://recoveryinthebin.org/ritbkeyprinciples/ Accessed 12th January 2021.
3. Recovery in the Bin Key Principles, page 2, https://recoveryinthebin.org/ritbkeyprinciples/ Accessed 12th January 2021.
4. Mary O'Hagan 15th August 2018. Health Central https://healthcentral.nz/opinion-mary-ohagan-more-needed-on-mental-health-menu-than-medication/ Accessed 13th January 2021.

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Further reading

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