LAND OF THE FREE

An anti-consensus consensus statement

Marcus Roberts discusses recent debates about 'recovery' in mental health, and asks whether too much consensus could be at odds with the concept's transformative potential and radical roots.

"Life is fired at us point blank and the question is not how to get cured but how to live."

Rowland Urey, mental health service user

"What we seem to have is the reification of the word recovery as though it is a thing that is then open to disputes about ownership, etc – as though it were like some newly discovered island about which people ask: 'What life can it support? Whose territory is it? Who does it belong to?'"

Dr Glenn Roberts, rehabilitation psychiatrist

My first serious encounter with the idea of 'recovery' was in mental health. From the 1980s, 'recovery' was a banner around which the emerging service user movement rallied, to demand changes to mental health services and to society as a whole. This was an idea that was initially owned and developed by service users themselves.

Service users have also driven the recent development of 'recovery' in drug and alcohol policy. Those who argue for a rebalanced treatment system with better access to 'abstinence-based' approaches

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point to research that suggests this is what a large proportion of service users want from services. The Royal Society of Arts' report *Whole person recovery: A user centred approach to problem drug use* (2010) explains that service users were at the centre of an RSA project to develop recovery-based services in two locations in West Sussex (Bognor Regis and Crawley), concluding that service users want personalised interventions, a balance between psycho-social and medical interventions and 'whole community responses'. The 2010 Drug Strategy states that 'recovery is an individual, person centred journey' not 'an end state' and that it will 'mean different things to different people'.

Much of the early literature on recovery in mental health which appeared in the 1980s and 1990s was not about evidence-bases, clinical practice or research findings. It took the form of first person narratives, telling the stories of individual service users who had found their own ways of living full, satisfying and contributing lives, often despite a bleak prognosis from mental health services. This literature was as much about inspiration as information. Transplanted to a contemporary setting, its natural habitat is the message board, the social network and the blog.

There were various strands to this emerging recovery narrative. First, it protested that diagnostic labels like schizophrenia should not be regarded as 'psychiatric death sentences'. This was partly a protest against cures that felt worse than the illness – the sort of stuff Nurse Ratched dished out in *One Flew over the Cuckoo's Nest*. There are clearly some parallels here with recent controversy about the use of methadone. The role of mutual aid, peer support, recovery champions and service user involvement and representation are all crucial here as well.

Two different – but related – ideas of recovery were also critical for mental health: as defined by the Oxford English Dictionary, these are 'finding something you've lost' and 'regaining something that has been taken away'. In simple human terms what had been 'lost' or 'taken away' were things like choice, control, dignity, hope and aspiration. Partly this was about the experience of disempowerment within an often remote and impersonal treatment system. But critically it was about economic, social and political inclusion – about showing 'that many people who had been written off by mental health professionals were successfully finding ways of living full, satisfying and contributing lives, despite experiencing mental distress'.

A FUNDAMENTAL PRINCIPLE FOR THE RECOVERY MOVEMENT IN MENTAL HEALTH IS THAT LIVING BETTER SHOULD NOT BE CONDITIONAL ON GETTING BETTER

Recovery in this sense is distinct from 'recovery from illness'. A fundamental principle for the recovery movement in mental health is that *living better should not be conditional on getting better*. This was a departure point for what has arguably been one of the great – if unsung – liberationist political struggles of the last 50 years. Its legacies include, for example, the development of the Care Programme Approach, innovative Supporting People schemes, multi-disciplinary Community Mental Health Teams, legal protection against discrimination on mental health grounds enshrined in the Disability Discrimination Act 2005 and the multi-million pound Big Lottery/ Comic Relief Funded 'Time for Change' campaign against stigma. It is pertinent to add that this was as much a battle against discrimination based on *people's engagement with treatment* (including medication) as against their mental health status as such. For example, the reasonable adjustments that employers might be expected to make under the Disability Discrimination Act would include – say – adjustments to working hours to allow for the side effects of psychiatric medications.

The identification of recovery with social (re)integration has also been a feature of the concept's emergence in drug policy over the last five years. It was a theme in the last New Labour drug strategy, *Drugs: Protecting families and communities* (2008), with its promise of 'a radical new focus on services to help drug users to re-establish their lives'. This commitment was echoed in the *Drug Strategy 2010*, with a clear statement that recovery is critically about 'enabling people to successfully reintegrate into their communities', and detailed discussion of policies to improve access to housing and employment (themes that were subsequently taken up in the National Treatment Agency's *Building Recovery in Communities* consultation). But the differences between mental health and substance misuse are also evident – notably, much less official interest to date for the latter in issues of stigma and discrimination. DrugScope has invested a fair bit of energy trying to engage the Equality and Human Rights Commission with the social (re)integration agenda set out in the 2008 Drug Strategy, with little success.

The final parallel I'd note between the history of recovery in mental health and its more recent ascendancy in drug policy is that the 'consensus statement' appears to be as much a distinctive genre for recovery literature as the first person narrative. In May 2007 the Care Services Improvement Partnership, Royal College of Psychiatrists and Social Care Institute for Excellence published *A Common Purpose – Recovery in Future Mental Health Services*. In June 2008, the UK Drug Policy Commission's Recovery Consensus Group produced 'A vision of recovery', which itself built on a similar exercise by the Betty Ford Institute Consensus Panel in the United States. DrugScope's own report *Drug Treatment at the Crossroads* (2009), could also be viewed as a contribution to a burgeoning 'consensus' literature. All this time and energy put into building consensus is testimony to the combustibility and fractiousness of the recovery concept. This has most recently been evident, for example, in the controversy that followed the publication in June of the Centre for Policy Studies' (non-consensually entitled) *Breaking the habit: why the state should stop dealing drugs and start doing rehab*.

This tendency to fractiousness around recovery has been every bit as

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evident in the mental health field. Back in 2007, when I worked at Mind, the mental health charity, I was responsible for a roundtable seminar on recovery, which was marked by disagreement and controversy.

One of the complaints from some service user participants at the Mind event was that the government focus on employment was alien to the spirit of recovery. It was declared that 'many people with direct experience of mental distress are sick of the term recovery', because 'we seem to have moved from services that expect people to stay permanently unwell to the opposite – and for many this is just as oppressive'. At service delivery level, similar issues were raised about the transition from traditional day services providing community support (offering a cup of tea and a place to be to often isolated service users) to recovery services (offering skills development, job search and pushing people back out into the world). The idea of the Department for Work and Pensions assuming lead responsibility for recovery in the 2010 Drug Strategy would certainly have raised eyebrows among many mental health activists.

Others expressed shock at the 'negativity' of a lot of this criticism, highlighting positive examples of local recovery practice, welcoming the Government commitment to tackling economic and social exclusion, and with some even arguing that identifying as a 'service user' was 'anti-recovery', because it evinced an unwillingness to move on.

Perhaps the fundamental stumbling block in both mental health and drug and alcohol policy has been a tendency to think of Recovery (with a capital R) as a reified thing, and to expend energy battling over its ownership and 'the one true meaning'. Recovery is not the same as either residential rehabilitation or employment, for example – such equivalences are not so much wrong as reflecting a misunderstanding of the root idea of recovery. It is not a specific thing or outcome or intervention, but a process (as the 2010 Drug Strategy recognises). This is as true of the recovery paradigm as a framework for policy development as for the process of negotiating individual recovery pathways in drug services.

PERHAPS THE FUNDAMENTAL STUMBLING BLOCK IN BOTH MENTAL HEALTH AND DRUG AND ALCOHOL POLICY HAS BEEN A TENDENCY TO THINK OF RECOVERY (WITH A CAPITAL R) AS A REIFIED THING

Nor is recovery simply a descriptive term, it is a highly evocative one that engages people's passions and inspires commitment. Yes, we need to build a broad consensus around the sort of definition proposed by the UK Drug Policy Commission and the 10 principles of recovery set out in 2008 in the Sainsbury Centre for Mental Health's *Making recovery a reality*. Equally, we need to embrace multiple voices to keep in play the various dimensions of the recovery vision – including service user voices to challenge the tendency to the systematisation and codification of recovery by statutory agencies. Perhaps one of the main benefits of 'recovery' as an idea is its potential to open up the space for a renegotiation of power and control. Philosophers talk about 'essentially contested concepts', which have been wonderfully defined as '*concepts the proper use of* which inevitably involves endless *disputes about their proper uses* on the part of their users'. I'm not sure 'recovery' would technically qualify as essentially contested, but, while it can be a troublesome and turbulent idea, we should not be too quick to come to a shared view and put it back in its box.

All the quotations on recovery in mental health are from the Mind publication '*Life and times of a supermodel: The recovery paradigm for mental health*' (2008), which is available online at www.mind.org.uk/assets/0000/0347/mindthink_report_3.pdf

Anyone interested in the development of the recovery paradigm in mental health should read this together with the Sainsbury Centre for Mental Health's 2008 report '*Making Recovery a Reality*' at www.centreformentalhealth.org.uk/pdfs/Making_recovery_a_reality_policy_paper.pdf

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