The mainstreaming of recovery

Diana Rose

EDITORIAL

The mainstreaming of recovery

Recovery is everywhere. I am not the first person to say it was invented by the service user/survivor movement (Deegan, 1988) and subsequently taken up by mental health professionals (Repper & Perkins, 2003). I will not repeat the quote by Anthony which everyone deploys (Anthony, 1993). This editorial seeks to make a stronger case by looking at how the recovery movement gained traction, especially in the English-speaking world, and what the consequences are both for mental health practice and society more widely. I will contend that what began as a liberatory discourse has become instrumentalised and mainstreamed such that it is aligned perfectly with our neoliberal present.

Who could be against recovery? The emphasis on hope is something with which I have no quarrel, having once been told that I had none. But the recovery movement interprets this in a particular way and it is with an ideological slant that will reappear throughout this editorial. Consider a piece of research, a collaboration with service user researchers (Crawford et al., 2011). This was a nominal group study seeking to find out how service users, with either a diagnosis of psychosis or affective problems, ranked outcome measures commonly used in trials. Here, I will consider the group with a diagnosis of psychosis. Their top-ranked outcome measure was of side-effects of medication: this is what mattered most to them in terms of the outcomes of interventions. The Recovery Star ranked in the middle. Service users were critical of measures of function, pointing out that not socialising with others or breaking connections with families was not necessarily dysfunctional but a way of protecting one's mental health. My point is that such aspirations are not absent from the recovery movement and associated measures. For all that goals are meant to be ''personal'', certain goals are not permitted. You can not decide to go to bed for a month.

I would argue that certain goals are not permitted because the recovery movement is shot through with what we can call ''normalisation''. This concept originated in the learning disabilities field with Wolfensberger (1970), but not all people with learning disabilities liked the idea of being ''normal''. Hence the advent of groups like ''People First'' in the UK. In the twenty-first century mental health practice, service users are encouraged to be normal. And now I will tell you a story. We can call it a ''case history'' of $N = 1$.

The story concerns a woman who was admitted to a ''recovery house''. The reason for the admission was that she was on a high dose of chlorpromazine, had experienced postural hypotension and fallen face-first through a glass door

thus sustaining facial injuries. She had been admitted to an acute ward previously and her consultant decided she could not be left alone and ''needed nursing''. The ethos of the recovery house was indeed normalisation. No matter how distressed, the residents had to go about their daily business as normally as possible. There then arose a particular task. The woman ran out of one of her regular medications. The staff in the recovery house told her she must go and get a repeat from her GP as this was what she would normally do. It was a 20 mile round trip by public transport and she was distressed. There was a psychiatrist on the team but getting the prescription from him would not have been normal. She made it to the GP who was furious saying he could have faxed the prescription to the recovery house. Having completed the task, there ensued a conversation between the woman and one of the recovery house workers. The woman was in extreme distress but the response of the worker was upbeat ''you succeeded, you achieved the goal, you got the prescription''. The woman discharged herself.

This is in fact what some call an ''auto-narrative''. The woman was myself and I have several reflections. I have told this story in my teaching and one response is to say, ''oh, but that's not recovery: that is cruel''. I disagree. The ethos of the recovery house fitted perfectly with the kind of normalising discourse I discussed earlier. Second, only certain kinds of people could make it in the recovery house. They were nearly all middle class, younger women with depression or so-called ''personality disorder''. All were of white ethnicity. This was in stark contrast to the make-up of service users in the acute ward who were on the whole poor men from BME groups with a diagnosis of psychosis. Finally, the staff in the recovery house was mostly new psychology graduates. They matched the demographic of the residents and it is interesting that the mainstreaming of recovery is happening at the hands of psychologists. My point is that not everyone can make it in recovery services so they become yet one more thing at which service users can fail.

Recovery is said to be ''personal'' (Slade, 2009); it is ''deeply individual''. Why would anyone object to that? Because we are not isolated individuals, to put it bluntly. Focusing on the psychological make up of individuals, whether through depth psychology or CBT, is to dilute and render unimportant the social relations in which we are embedded and which shape and form us. In a real sense, we are those social relations. To some such statements are affronts. Modernist discourse has it that every individual is unique, a cluster of attributes special to each. Such sentiments

lie behind the current rejection of ''one size fits all'' approaches, for example. I do not mean to advocate reverting to homogenous services in mental health but I do mean that mental health service users have something in common, something not too far away from capture by a specialist discourse and practice and marginalisation by mainstream society. And the recovery movement, I would argue, is becoming a substitute specialist discourse and practice and confronts stigma and discrimination precisely by reference to normalising individualism. Recovery Colleges, for example, include courses premised on the idea that mental illness can happen to anyone. This is despite decades of work on epidemiology and health inequalities.

Empirical work on recovery is increasing but still there are significant gaps. Writing in this journal Marit Borg and colleagues (Borg & Davidson, 2008; Borg & Kristiansen, 2004) have attempted to discover what recovery means to service users using qualitative methods. However, they have only interviewed people deemed ''recovered'' and so there is an absence of work on what recovery means to people who continue to struggle.

There is a small sociological literature on recovery which takes the form of commentary and critique and which is interesting. Harper and Speed argue that, paradoxically, a strengths model of the service user continues to imply a deficit model because the strengths at stake are there to remedy on-going deficits (Harper & Speed, 2012). This work is also in line with the argument above that we are not isolated individuals as it looks to collective existence and collective action to improve mental health services in a way that service users want. The importance of collectives to validate and reflect on experience is also stressed by Pilgrim (2009), who makes the additional point that we do not really know what goes on in recovery services. Manualised interventions will not tell us this and Pilgrim calls for ''practice-near'' ethnography.

One aspect of recovery discourse deserves special mention. This is the twin claim that every service user should work and that traditional services, such as day centres, encourage dependency. Work will set you free; the autonomous individual is in control. So does a recovery discourse align itself with both service reconfigurations and welfare benefits cuts. In the UK, service users are being discharged from secondary mental health services back to the care of their GPs in their thousands and for those who do receive a service it is now often time-limited. From a recovery perspective, while obviously not advocating neglect, shaking free of services at least ultimately is all to the good. There would appear to be no understanding that some service users seek continued support and, in the current climate in the UK, live in fear that they will be ''found out'' by officials in charge of government policy to get disabled people back to work.

A further aspect of some versions of recovery is the advocacy of peer support workers. On the one hand, peer support workers are claimed to have a special knowledge because they have experienced the treatments and services in which they now work to support others at an earlier stage of the recovery journey. Although in some ways a progressive move, two points can be made about peer support workers.

First, they often find themselves in a position of tension because they have to fulfil two, sometimes contradictory, roles. They answer to two masters who require different things, that is, service users do not always want the things that clinicians prescribe (Fabris, 2011). But second, they are a subsidiary labour force commanding neither the respect nor the financial remuneration of mainstream staff. They are cheap labour. Some are not paid at all. So once again, we see an alignment between the financial restructuring of society and the recovery discourse. Peer support workers can be seen as part of the army of the Big Society.

So what am I proposing? Not a rejection of every part of the recovery discourse and practice. But we have to tackle head on the fact that our society is intolerant of difference. And people labelled mad are the most frightening group of the different because they threaten to expose the insanity that lies beneath the surface of all. Language is actually shifting in recognition of this. From ''stigma and discrimination'' to ''marginalisation'' to ''social exclusion''; even to ''oppression''. These shifts are interesting because they move us from the individual to the group. And my suggestion would be that we try to reclaim our rights at the level of the group. The normalisation that runs through the recovery discourse is focused on the individual. Group activity and campaigns were stronger 30 years ago than they are today with collectives such as ''Survivors Speak Out''. Now it seems we do not wish to upset anyone. I suggest we be upsetting, that we use humour and that service users should take the lead in this rather than follow in the wake of recovery workers.

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