

Revolution in the head¹

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1. Introduction: The discovery of recovery

There should no longer be a single account of the illness experience, refracted through a medical perspective...The recovery movement, unlike some other user movements, is not fundamentally based on opposition or grievance and is not anti-psychiatry. It centres on an outward, pro-recovery approach, offering a broad, inclusive, humanistic philosophy that could unite professionals, service users and others in the collaborative project of working for better lives for those who experience severe mental health problems.²

As “recovery” gains traction in the ideas marketplace of drug policy and treatment provision those in the mental health field may look on with a little bemusement: recovery has been a key (but not uncontested) driver in mental health service development for the past 15-20 years, and has roots that lie deep in the reform movements of the 19th century. Given the thematic overlaps mental health recovery movements represent rich sources of knowledge, and experience for their colleagues in addiction research and practice.

In the UK, recovery-orientated service reconfiguration draws largely on US experience in delivering recovery orientated systems of care in addiction services. However, socio-cultural differences between the US and UK alert us to the fact that this approach may have its limitations. In order for a robustly indigenous UK recovery ecology to develop and flourish, the grass-roots ethos that characterizes recovery movements will need to be tempered with multidisciplinary knowledge transfer and a reflective, critical approach at this formative interstice in the history of society’s response to addiction and substance use.

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² Glen Roberts & Paul Wolfson, “The rediscovery of recovery: open to all”, *Advances in Psychiatric Treatment*, **10**, 2004, p. 45 (37-49).

2. Origins

In contrast to previous mental health reform movements (such as de-institutionalisation) which were predominantly informed by professional and organisational needs, mental health recovery emerged as a grass-roots critique of mental health services and resistance to the hegemony of professional power. The mental health recovery movement is not monolithic, but a diverse and evolving collection of ideas, beliefs, and practices. This heterogeneity reflects mental health recovery movement's manifold influences, which include:

- Early mental health self-help and mutual aid groups; e.g. “We Are Not Alone” (1940's), and Alcoholics Anonymous mutual aid groups.
- Civil rights, liberation, and social justice movements of the 1960/ 70's, e.g. women's rights movement, gay rights movements, disability rights movements.
- Anti-psychiatry movement (challenging the professional assumptions that lie behind the “psy” sciences - psychiatry/ psychology/ psychotherapy).³
- Consumer/ survivor movements and the emergence of voices of recovery; e.g. Network Against Psychiatric Assault, Mental Patients' Liberation Front (1970's).
- Growing evidence-base revealing positive outcomes challenges long-held assumptions that serious mental illness is an intractable, degenerating condition.⁴

3. Mental health recovery: Key themes

A brief overview of some the key themes of mental health recovery movements illustrate how didactic these lines of thought and practice can be for the nascent addiction recovery movement.

- Self-empowerment and autonomy: taking responsibility and control.⁵ This can be understood ‘both systemically—as the power held by the state and the

³ See Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, an abridged version of *Folie et déraison. Histoire de la folie à l'âge classique*. A full translation is now available: Michel Foucault, *The History of Madness*, trans. Jean Khalifa, Taylor & Francis, London, 2006.

⁴ See R. Warner, *Recovery from Schizophrenia: Psychiatry and Political Economy* (3rd ed), Brunner-Routledge, New York, 2004. See also Kim T. Mueser *et al.*, “Illness Management and Recovery: A Review of the Research”, *Psychiatric Services*, **53**:10, 2002, pp. 1272-1284.

institution of psychiatry, and individually—as the consumer taking control and responsibility for his or her own life’.⁶

- Formation of a new identity or sense of self. Conversely, some mental health activists and theorists affirm recovery as the retrieval, reclamation, or integration of the self.⁷
- Recovery understood as both a process and an outcome,⁸ a journey that can ‘take people to a higher level of functioning than before’.⁹
- Building a meaningful life and gaining a mainstream social identity - a ‘place of equality in society’.¹⁰ Recovery from ‘social exclusion, stigma, labeling, restrictions, civil rights, discrimination, guilt and shame’.¹¹
- Multiplicity of individual perspectives (“survivor”/ “client”/ “consumer”/ “ex-patient”) and the singularity of the experience: recovery as a unique, personal journey.
- Hope and optimism:
 - i. Proactively challenging the “learned hopelessness” arising from negative clinical language.¹²
 - ii. Recognising diverse but positively perceived outcomes that exist along a continuum of equally valued possibilities.
 - iii. Attitudinal components of “hope”:¹³

⁵ After R. Andreson, L. Oades, and P. Caputi, “The experience of recovery from schizophrenia: towards an empirically validated stage model”, *Australia and New Zealand Journal of Schizophrenia*, **37**:5, 2002, pp. 586-594.

⁶ Nora Jacobson and Laurie Curtis, “Recovery as Policy in Mental Health Services: Strategies Emerging from the States”, *Psychosocial Rehabilitation Journal*, Spring, 2000, p. 2 (1-14).

⁷ See Joseph A. Fardella, “The Recovery Model: Discourse Ethics and the Retrieval of the Self”, *Journal of Medical Humanities*, **29**, 2008, pp. 111-126; P. Campbell, “It’s not the real you”, *Open Mind*, **111**, 2001, pp. 16–17.

⁸ D.P. Liberman and A. Kopelowitz, “Recovery from schizophrenia: a concept in search of research”, *Psychiatric Services*, **56**, 2005, pp. 735–742.

⁹ S. Bonney & T. Stickley, “Recovery and mental health: a review of the British Literature”, *Journal of Psychiatric and Mental Health Nursing*, **15**, 2008, p.141 (140-153). See P. Chadwick, “How to become better after psychosis than you were before”, *Open Mind*, **115**, 2002, pp.12–13.

¹⁰ Bonney and Stickley, 2008, p. 148. See MIND, *Understanding Schizophrenia*, London, 2005.

¹¹ See W. Anthony, “Recovery from mental illness: the guiding vision of the mental health service system in the 1990s”, *Psychosocial Rehabilitation Journal*, **16**, 1993, pp. 11–23; P. Deegan, “Recovering our sense of value after being labeled mentally ill”, *Journal of Psychosocial Nursing*, **31**, 1993, pp. 7–11; L. Sayce, *From Psychiatric Patient to Citizen*, Macmillan Press, Basingstoke, 2000; S. Stanton, “Inescapable past?”, *Open Mind*, **111**, 2001, p. 15; C. Buckingham, “Schizophrenia – the biological and social”, *Open Mind*, **111**, 2001, p. 11; R. Hope, *The Ten Essential Shared Capabilities – A Framework for the Whole of the Mental Health Workforce*, Stationery Office, London, 2004; Chief Nursing Officer (CNO), *Chief Nursing Officer’s Review of Mental Health Nursing Consultation*, Department of Health, London, 2005.

¹² Bonney and Stickley, 2008, p. 149. See R. May, *Understanding Psychotic Experience and Working Towards Recovery*, Bradford District Community Trust, Bradford, 2001; P. Bracken and P. Thomas, “Hope”, *Open Mind*, **130**, 2004, p. 10.

- Recognition and acceptance
 - Commitment to change
 - Focus on personal strengths rather than pathologies
 - Cultivating optimism
 - Appreciation of incremental growth rather than instantaneous transformation
- Freedom to make mistakes and take risks.¹⁴ Recovery is about ‘potential and expectation, not the lowest common denominator of keeping everyone safe, taking no risk of failure’.¹⁵

4. Being comfortable with confusion: Implications for addiction recovery

What is striking about mental health recovery is its radically plural character: as has been discussed, given the manifold influences and developmental trajectories it is best understood as a collection of movements rather than singular phenomenon. As Jacobson and Greenley note, this lack of specificity has led to a certain amount of confusion:

Recovery is variously described as something that individuals experience, that services promote, and that systems facilitate, yet the specifics of exactly what is to be experienced, promoted, or facilitated – and how – are often not well understood either by the consumers who are expected to recovery or by the professionals and policy makers who are expected to help them.¹⁶

Rather than indicating any inherent conceptual weaknesses, this confusion can be attributed to the fact that mental health recovery ‘is the product of the convergence of two very different forces’:¹⁷ namely, recovery as a complete amelioration of symptoms (based on longitudinal outcome studies) and recovery as an acceptance of symptoms and mental illness as being ‘only one aspect of an otherwise whole person’,¹⁸ (based on consumer/ survivor voices). These oppositional forces contribute

¹³ Adapted from Nora Jacobson and Dianne Greenley, “What Is Recovery? A Conceptual Model and Explication”, *52:4*, 2001, pp. 482-483 (482-485).

¹⁴ See D. Martyn, *The Experiences and Views of Self Management of People with a Schizophrenia Diagnosis*, Rethink, London, 2002; M. Romme and S. Escher, *Making Sense of Voices*, Mind Publications, London, 2000.

¹⁵ Bonney and Stickley, 2008, p. 148. See V. Gould, *A Carer’s Perspective on the Recovery Journey*, Scottish Recovery Network, Glasgow.

¹⁶ Jacobson and Greenley, 2001, p. 482.

¹⁷ Larry Davidson *et al.*, “Recovery in Serious Mental Illness: A New Wine or Just a New Bottle?”, *Professional Psychology: Research and Practice*, **36:5**, 2005, p. 480 (480-487).

¹⁸ *ibid.* p. 481.

to a reification of “old” and “new” conceptualisations of recovery and the tension between them persists in an era of evidence-based health care.¹⁹

As the embryonic addiction recovery movement in the UK attempts to reconcile a univocal understanding of recovery inherited from the principal 12-Step mutual aid traditions (specifically AA and NA, which tend to affirm abstinence as the necessary starting point of recovery) with the realities of substance use and medically assisted recovery, the mental health recovery movement’s accommodating approach to analogous concerns should be seen as instructive. Broadly speaking, mental health services have no trouble recognising a miscellany of positive recovery outcomes.²⁰

5. Conclusion

“Recovery” is being positioned as a radical re-visioning of addiction service culture and delivery. In a climate of uncertainty precipitated by relentless service retendering, speculation over future funding, and an anticipated change in administration, drug and alcohol service providers and commissioners have every reason to look at alternative ways of delivering services. However, pursuing a solely top-down approach to reconfiguration risks replacing one regime of institutional truth with another, resulting in prolonged iatrogenesis and the continued exclusion, marginalisation, and stigmatisation of those who are directly affected by substance use.

Mental health recovery does not hold all the answers. One cannot import ideas or ideologies wholesale from the mental health field; its history and social context is quite distinct from the addiction field and key concepts and their associated theoretical *milieux* do not always translate well (the concept of “consumer” for example).²¹ Nevertheless, as I hoped to have illustrated, mental health recovery

¹⁹ See Shulamit Ramon, Bill Healy, and Noel Renouf, “Recovery from Mental Illness as an Emergent Concept and Practice in Australia and the UK”, *International Journal of Social Psychiatry*, **53**, 2007, pp. 108-122.

²⁰ See Warner, 2004. Warner, whose analysis of 85 longitudinal studies dating back to the early 20th century revealed the reality of diverse outcomes for mental health recovery, distinguishes between ‘complete recovery’ (occurring in 20-25% of populations studies and indicating a ‘loss of psychotic symptoms and return to pre-illness level of functioning’), and ‘social recovery’ (occurring in 40-45% populations, designating a regaining of ‘economic and residential independence and low social disruption’). Such a distinction is a useful starting point for advancing an inclusive and progressive account of recovery from addiction.

²¹ See William White, “A commentary on ‘consumer’: Language, stigma and recovery representations”, 2009. Available:

discourse is suffused with congruent concerns and there is demonstrable value in pursuing bilateral knowledge transfer between the two fields. The most significant lessons perhaps come from the obstacles that are faced when implementing recovery-orientated changes.²² For example, Bonney and Stickley caution that:

With such a current focus upon risk in Western society it is virtually inconceivable that statutory health care providers will ever fully embrace the recovery paradigm that involves self-management and has choice, hope, freedom and autonomy at its core. Furthermore, these values are extremely difficult to measure in a system that revolves around targets and outcomes. While there may be workers within the system that genuinely subscribe to recovery principles, they will struggle to practise according to those values in a system that pays only lip-service to a philosophy that is very dependent upon human values and beliefs.²³

Recovery is a potent and multifaceted concept that resists positivistic reduction yet the vibrancy of mental health recovery movements and the extent to which administrations have embraced recovery praxis indicate that the plasticity of the concept need not be a barrier to implementation. Concerns that recovery-orientated provision cannot be reconciled with the gold standards of evidence-based health care present a notable challenge to recovery researchers who traditionally privilege qualitative methodologies that score low in evidence hierarchies. However, as Anthony *et al.* point out:

The notion of evidence-based practices and recovery-oriented services can work well together. However, if evidence-based practice research is to inform the development of recovery based services, then the concept of evidence-based practice must be broadened ... Recovery-oriented system designers, programme planners and clinicians must be aware that their current efforts remain guided by the best available evidence, while we accumulate the best evidence possible.²⁴

Whilst recovery researchers attend to the business of accumulating the best *possible* evidence, you don't have to look far to find the best *available* evidence.

http://www.facesandvoicesofrecovery.org/pdf/White/2009Language_OnConsumer.pdf, retrieved 20th November, 2009, 08.48.

²² See Davidson *et al.*, "The Top Ten Concerns About Recovery Encountered in Mental Health System Transformation", *Psychiatric Services*, 57:5, 2006, pp. 640-645.

²³ Bonney and Stickley, 2008, p. 150.

²⁴ W.A. Anthony *et al.*, "Research on evidence-based practices: future directions in an era of recovery", *Community Mental Health Journal*, 39, 2003, p. 112 (101–114).