RECOVERY ARTICLE FOR MENTAL HEALTH TODAY

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It might be an exaggeration to claim there are two versions of recovery in the mental health world today. Both the service user movement and psychiatric rehabilitation versions overlap and some of the differences are in emphasis only. But the ownership of these versions differs and so do some of the fundamental beliefs they rest upon.

I've been watching and contributing to the growth of the international recovery movement in mental health for many years. I first noticed the word coming out of America in the early 1990s from psychiatric rehabilitation establishments whose purpose was to help people overcome their functional limitations. Recovery at that time was most often portrayed as an intensely personal journey; coming from America's strong cultural context of Christianity and individualism, it seemed almost like a form of secular salvation. At the same time, some people in the user/survivor movement in America were starting to talk recovery. Their purpose did not arise so much from an assumption of personal deficit as from an assertion of their right to self-determination.

In New Zealand in 1998 a group of service users were asked to describe a new philosophy of mental health services in a key government document, *The Blueprint for Mental Health Services in New Zealand* http://www.mhc.govt.nz/documents/0000/0000/0009/BLUEPRINT1998.PDF. We had doubts about the word 'recovery' but couldn't find another term, so we decided to expand what we meant by it. The American literature at the time was strong on the personal journey of recovery but we wanted to emphasise the social, economic and political dimensions of recovery and to replace the deficits approach that underlay some of the literature with an explicit platform of self-determination. By the turn of the millennium a good number of users and survivors in English speaking countries were writing about recovery from the platform of self-determination.

In England the new National Institute for Mental Health in England started to champion recovery and appointed a recovery lead who did not identify with the user/survivor movement. Service user leaders in England were suspicious. There were semantic issues with the word recovery, it was an import from America, and they believed that service users should lead recovery, not professionals.

At the same time in New Zealand, service user leaders claimed leadership in the development of recovery with some success. We integrated the legitimisation of madness, human rights, the reduction on compulsory treatment and anti-discrimination into our understanding of recovery. Over the years some of us have worked on the features of a recovery based service system. See, for instance: *Destination: Recovery* http://www.mentalhealth.org.nz/resources/Destination-Recovery-2008.pdf

In the meantime in England, recovery started to appear in official documents. More agencies and professionals began to champion it. So did some service users. But I still have the sense that recovery in England is largely led by professionals with a psychiatric rehabilitation slant. In New Zealand on the other hand, we are starting to sense a professional backlash against recovery. Perhaps we should have got more professionals on board with recovery in New Zealand, but service users certainly need the opportunity to lead recovery in England.

Recovery can be seen through different lenses – as a personal experience, as a set of workforce competencies or practices, or as a whole system. It can also be viewed as the first genuinely post-

institutional service philosophy. As such it must challenge the bedrock of beliefs the mental health system of the institutional era has been based upon. These beliefs still drive our thoughts and feelings, our behaviour and our systems, so pervasively that we are often barely aware of them. The service user movement version of recovery has been quicker to recognise the need to challenge these bedrock beliefs than the psychiatric rehabilitation version.

Perhaps the most fundamental institutional era belief that still drives services is the view that madness has no legitimacy. Most people experience major mental health problems as frightening, desolate and even destructive. The pain of madness is probably on a par with major grief, torture, surviving a battlefield, or being falsely accused of a serious crime. There's a big difference though; these other experiences have legitimacy. Society enables a pathway though them towards growth, recovery or justice. Though they are not well understood by the majority, surviving them is often regarded as admirable or heroic. Madness however, is met with pity, fear and reproach. It does not have status as a full human experience, and this has provided justification for cruelty, segregation and coercion. No society or mental health system built on this bedrock belief will ever do well for people with major mental health problems. The recovery philosophy however, undoes our traditional beliefs about madness by giving it meaning, full human status and a pathway to a better life.

Another bedrock belief, or rather consensus, is our communities' abdication of responsibility for its marginalised citizens, to professionals and services. In comparison to a century or more ago, people seek many more answers to human problems from state-authorised professionals and services. In some respects this has been of benefit. But dependence on deficits-oriented professionals and services, with their reputed monopoly on expertise has disabled communities and individuals. Traditionally, and in some ways unwittingly, the mental health system has perpetuated its power, resources and beliefs about madness by keeping people stuck in services.

The recovery philosophy implies that people with mental health problems as well as their communities need to start believing they hold most of the solutions to human problems, instead of just professionals and services. We need to start viewing mental health professionals and services, as the carriers of technologies that we may want to use at times, just like architects, plumbers and hairdressers. At the same time the mental health system needs to hand over control to service users and their communities, through fostering service user leadership in personal recovery and in services, through integrating with other sectors, and engaging in community development and social inclusion work.

The devaluing of madness combined with community abdication has led to a naive and simplistic community consensus around personal safety and mental health, based on a discriminatory assumption that mad people cannot be responsible for their behaviour. Therefore mental health experts and services must take total responsibility for people with mental distress, particularly those in crisis, who should be contained and tightly controlled. When something goes wrong mental health services are fully to blame. There are some unsustainable assumptions in this consensus - that mad people like robots, have no free-will, that professionals have magical powers of prediction and that coercion will make communities much safer. Unfortunately, this unrealistically demanding consensus has led to risk-averse practices in mental health, such as compulsory treatment, locked doors and other restrictions on liberty.

The recovery philosophy suggests that mental health practitioners and spokespeople in the public arena need to challenge this consensus instead of colluding with it as they routinely do now.

In my view, the mental health systems in both our countries are in woeful states. There are good services but they are the exception. There are plenty of good people working in mental health but they are confined by outmoded beliefs, expectations, practices and structures.
If recovery leaders - whether they identify as professionals, service users or both, whether they were moulded by the service user movement or psychiatric rehabilitation - don't name and dismantle these beliefs and expectations, the mental health system will continue to do a disservice to many of the people who use it.