mind

For better
mental health

Life and times of a supermodel

The recovery paradigm for mental health

MindThink report 3

Participants

This report is based on a roundtable discussion held in 2007. The views of participants varied. This report captures some key issues discussed at the seminar, and what Mind believes were some of the most interesting proposals for change. It should not be assumed that all individual participants would agree with all of its recommendations.

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Introduction

On 3 December 2007, Mind held an expert seminar to discuss the results and prospects of the recovery approach to mental health, and in particular to consider rival interpretations of the concept of recovery and their impact on mental health (and related) services in England and Wales.

The seminar was held in our MindThink series, in association with the Social Perspectives Network (SPN) and the Centre for Ethnicity and Health at the University of Central Lancashire (UCLAN). The purpose of MindThink seminars is to bring together experts, stakeholders and opinion formers to scrutinise, examine and debate some of the most challenging issues for mental health policy. These seminars are conducted in accordance with Chatham House rules. Unless otherwise specified, all the quotations included in this report have been subsequently agreed with the people to whom they are ascribed.

MindThink seminars have a particular focus on the future direction of policy; on the fundamental questions and assumptions that lie at the heart of our thinking about mental health; and on critical scrutiny of attitudes and assumptions that are often taken for granted. Each event brings together service users, professionals, policy experts and advisors, academics, journalists and other opinion formers to spend a day discussing a key issue.

The aim of our MindThink work is to promote debate, not pre-empt it; to provide creative space for progressive policy ideas to flourish, not to arrive at a list of definitive policy prescriptions; to allow people to speak freely and to exchange ideas, not to have the last word.

The purpose of the recovery seminar was to consider the strengths and limits of current understandings of recovery and to assess the impact of recovery approaches on front-line service provision and service users. Key questions included: What are the strengths of current versions of recovery? What concept of mental distress underpins current thinking about recovery? How is 'recovery' defined and by whom?

An open discussion of the results and prospects of the recovery paradigm seemed timely for

"Recovery now sits beside choice, independence and inclusion as the watchwords of modern mental healthcare."

Louis Appleby (in CSIP et al, 2007)

"Once a concept is taken up officially, it is a good bet that it will be defined and used in a way that won't reflect the understandings and values of people who framed it and need it."

Derek Draper

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

Rowland Urey

"An emphasis on recovery is of no value if it is not authentic and both clinically and intellectually robust: doubt and debate are essential elements of a healthy developmental process."

(Roberts and Hollins, 2007)

"Genuine growth and development of recovery-based practice and practitioners depends on honest and open discussion that acknowledges difference and disagreement but is centred on the search for common objectives and a collaborative way forward."

(CSIP et al, 2007)

a number of reasons. Firstly, policymakers, professionals and other service deliverers are increasingly appealing to the ideal of recovery as the guiding star for mental health policy development. On the face of it, this is a welcome development. However, secondly, there is widespread unease about the current trajectory of (some) recovery-based policy and practice from leading figures in the service user movement (among others). And, thirdly, leading professional champions of recovery – including the Care Services Improvement Partnership (CSIP), Social Care Institute for Excellence (SCIE) and the Royal College of Psychiatrists (RCPsych) – recognise that there is "difference and disagreement" in this area, and have called for an open and honest debate as a condition for moving forward in a collaborative and constructive way.

Our intention was that this seminar would make a contribution to this process. Certainly, it provided a good opportunity to explore disagreement in an open discursive environment. The issues were ably and engagingly articulated by presenters and the standard of debate was high. Most of the feedback we received was positive.

At the same time, what was perhaps most striking about this seminar was the strength and passion of some of the disagreements. These began even before the seminar itself, when concerns were expressed about the representativeness and balance of literature sent out in advance. They continued afterwards in the form of some significantly differing assessments of the tone, trajectory, content and value of the discussion on the day.

On the one hand, some service user participants feared that official versions of recovery were little more than an ideological gloss for regressive welfare policies and cuts to mental health services. On the other, one of the professional participants openly argued that the very act of identifying as a service user could be anti-recovery and suggested that the organised service user movement was increasingly obstructive and anachronistic.

One thing that clearly emerged from this seminar was that there is genuine and passionate disagreement about the trajectory and prospects

of recovery. This division did not map neatly on to that between those with direct experience of mental distress and professionals (in so far as this distinction can be made). Some 'service users' wholeheartedly endorsed current forms of recovery practice; some providers were sceptical about it.

To what extent these differences were substantive, and to what extent they rest on differing definitions and perceptions of recovery is one of the questions for this report. Its aim is to get beyond and behind these disagreements, to identify and examine the issues that gave rise to them and to make some proposals that might help in "the search for common objectives and a collaborative way forward."

> "Who are we? What are we? Why are we here? These are not simply moral issues, they are also political... recovery came out of the civil rights movement of the 1960s. It is about a vision of a life lived to the full – with passion, humour, style."

Unless attributed to another source, all quotes are from the transcripts of the seminar held by Mind in association with Social Perspectives Network (SPN) and University of Central Lancashire (UCLAN) at the Resource Centre, Holloway, London on 3 December 2007. This report summarises and discusses some of the main issues from the day. As will be clear, participants had differing views. It has not been possible to capture every detail of these disagreements in a short report. Nor is it possible to provide a completely exhaustive or necessarily an entirely balanced account of the day. To this extent, the report reflects its authors' take upon the debate.

Life and times of the recovery approach

As Jan Wallcraft argued in her presentation, the recovery approach was pioneered and developed by service users. It posed a challenge to mental health service providers and a wider society for whom the social exclusion of people with mental health problems and their disempowerment by the mental health system were largely unchallenged. A number of influential articles were published in the 1980s and 1990s in the form of first-person narratives tracking the personal journeys of service users. They showed 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.

What is recovery?

One sense in which recovery has forced itself on to the agenda of mental health services in the past 30 years has been the narrowly medical one: 'recovery from illness'. Research has shown that the prospects of recovery in this narrow sense are pretty good. Research by Harding et al. published in the early 1990s concluded that after an average of 32 years of follow-up, two-thirds of a cohort of 'severely disabled', long-stay patients significantly improved or recovered from psychiatric illness (discussed in Turner-Crowson and Wallcraft, 2001; pp 4–5). *A Common Purpose* states: "recovery rates for mental illness are noted to surpass the treatment success rates for many other physical illnesses, including heart disease. The National Advisory Mental Health Council (NAMHC) states that recovery rates include: schizophrenia, 60 per cent; bipolar disorder, 80 per cent; major depression, 65–80 per cent; and addiction treatment, 70 per cent." (CSIP et al, 2007; p. 8)

These findings challenged the bleak prognoses that had been common within mental health services and have been reflected in negative and stigmatising social attitudes and public policies. But the real focus of the recovery movement was about recovery in a different and wider sense. Fundamentally, it was about the recovery of hope and aspiration, self-esteem and control,

"Once we start talking about this reified thing – Recovery with a capital 'R' – it gets us into the wrong debate. As a guiding purpose for working with people experiencing mental health problems it is hard to argue with recovery. But what is thought of as the recovery agenda is more controversial and not everyone is comfortable with embracing that. In part, this reflects misunderstanding of what the 'recovery agenda' is and the implications for all involved, which in turn reflects the range of uses and misuses of the recovery concept."

Glenn Roberts

"It is instructive to look at the three definitions of recovery that are provided in the shorter OED: recovery from illness, finding something you've lost and regaining something you've had taken away. All these are relevant. Politically active service users know what recovery means – it is about a political process – those with mental health problems have been excluded from society. It is also about the power of psychiatrists to define people's experiences with labels such as 'schizophrenic' – which, in itself, is a barrier to recovery. It is about reclaiming language."

Phil Thomas

"Recovery is about paradigm shift – from reductionist models to holism, complexity and the real life experiences of service users. Psychiatrists do adhere to biomedical models – not because they are necessarily narrow in their focus as individuals, but because that is what they are taught, what defines their professional status and identity and it is what they have to rely on. For example, spirituality and values are banished from science. Recovery is a service user led concept – it is our concept and it is we who should define it."

Jan Wallcraft, service user and researcher

"Who are we? What are we? Why are we here? These are not simply moral issues, they are also political… recovery came out of the civil rights movement of the 1960s. It is about a vision of a life lived to the full – with passion, humour, style."

Rowland Urey, service user and recovery expert

social belonging and the ties of community, dignity and inclusion – and, crucially, about the recovery of these things despite continuing experience of mental distress. For many, in Rowland Urey's words, it was about "recovering from the misdeeds of psychiatry" – from bleak prognoses, the payload of exclusion inscribed within diagnostic labels such as 'schizophrenia' and the impact of inappropriate psychiatric drugs, treatments like ECT or long-term institutionalisation. On the one hand, then, recovery is about personal journeys and individual experiences. As an ideal, it has therefore found some of its best expressions in narrative accounts by individual service users. On the other hand, it sets a clear political agenda. Hope is liberating, but it can only take you so far. The horizons of recovery have been circumscribed by poor mental health services, excessive use of compulsion, lack of service user involvement, lack of choice of treatments, social exclusion, stigma and discrimination.

Recovery in a wider context

In the opening MindThink session, David Morris, Director of the National Social Inclusion Programme at the Department of Health, began by saying that the merit of recovery as a starting point for working with people experiencing mental health problems was "pretty well… unarguable." However, recovery had to be placed in a wider context. "It is important," he argued, "that we don't become over-focused on individuals and neglect the social contexts in which they live their lives. Recovery, in a narrow sense, is necessary, but not sufficient for social inclusion. People who experience mental health problems still face a distinctive set of structural inequalities and barriers. We cannot deliver on recovery without addressing these, too."

David Morris also stressed that recovery must be understood "in terms of the multiple communities of which individuals are part, of which the service user community is one." A related point was made by Dr Jayasree Kalathil of the Catch-a-Fiya network. Dr Kalathil noted that recovery journeys were situated within ethnically and culturally diverse networks of family, friends and community. The construction of narratives of recovery depends on wider cultural and spiritual

narratives and systems of meaning and belief (which will also influence conceptions of mental distress and recovery). Mainstream mental health services still struggle to give appropriate weight to the beliefs and experiences of people from minority ethnic communities. (These issues are discussed in more detail in the first MindThink report, *Putting the soul back into psychiatry*.)

> "For many people, recovery means having a positive sense of identity as part of a larger community. If that community is often negatively portrayed and discriminated against what effect does that have on one's recovery?"

Jayasree Kalathil added that "for black people it is not just 'culture' but the experience of institutional and societal racism that is a significant factor in their experience of mental distress and within mental health services. If recovery is the process of moving on to more empowering and meaningful ways of being, what does that mean to a person whose everyday experiences of living includes racism and discrimination?

For many people, recovery means having a positive sense of identity as part of a larger community. If that community is often negatively portrayed and discriminated against what effect does that have on one's recovery? A lot of services that claim to work within the recovery approach – and for which independent living is an important step – fail to engage with factors that hinder recovery, including the experience of racism."

She spoke of the need for more systematic work looking at what recovery means for people from BME communities. "One poignant BME narrative said that the journey to recovery only seemed possible when a psychotherapist engaged with the whole person, including the damage done by racism to this particular individual's identity and wellbeing.' Policymakers, professionals and service deliverers need to be more alert to the need to address different – but inter-related and often mutually reinforcing – sources of social exclusion in support of recovery. The mental health service user movement needs to work more effectively with other social movements – such as anti-racism and LGBT activists – on the recovery agenda."

Piers Allott, NIMHE Fellow in Recovery, made a similar point in his presentation. He argued that "recovery is not only about recovery from mental health problems ... recovery is part of the very fabric of life – which is marked by adversity, injustice, loss and fluctuation in physical and mental health. It can also apply to the experiences of communities and societies – for example, by the Maori in New Zealand." It could therefore be argued "that recovery is a gift that people with mental health problems have made to other groups and to society as a whole."

A common purpose?

Is there an 'official' version of recovery – and, if so, what does it look like? A good starting point is the joint position paper from the Care Services Improvement Partnership, Royal College of Psychiatrists and Social Care Institute for Excellence entitled *A Common Purpose – Recovery in Future Mental Health Services*, published in May 2007. It is a good starting point because it provides a vision of recovery that is endorsed by some of the key professional agencies, and which is lucid, rigorous, informed and inspiring, and – on the face of it, at least – is fully consonant with the original service user conception and agenda.

A number of the participants in the MindThink seminar contributed to this document. Glenn Roberts and Piers Allott were members of the steering group. The first version of the report was drafted by an SPN writing group, comprising Jan Wallcraft (Lead), Jerry Tew, Raza Griffiths and Vicky Nicholls. So, there is a good prospect of finding a broadly consensual vision of recovery here, with service user activists involved in its development and with the endorsement of key professional bodies.

A Common Purpose acknowledges the importance of the narrative testimonies of individual service users, "whose hope, resilience and capacity to live well, even in the context of on-going difficulties, offer an example and inspiration to others." (Roberts and Hollins, 2007). It is big on both the individual nature of recovery journeys and on the importance of culture, ethnicity and spirituality in providing their context – and, importantly, as resources that can shape and support recovery (for example, by providing a sense of meaning, identity and belonging).

A Common Purpose proposes therapeutic relations that are collaborative and negotiated. It makes the case for individual narrative as a corrective for narrow interpretations of evidence base that discount the value of first-person testimony.

It argues that "in order to support personal recovery, services need to move beyond the current preoccupations with risk avoidance and a narrow interpretation of evidence-based approaches towards working on constructive and creative risk-taking and what is personally meaningful to the individual and their family." (For a related discussion, see our second MindThink report *Chance would be a fine thing.*) In addition, while *A Common Purpose* distinguishes recovery from social inclusion, it is clear on their interdependence, too. Recovery depends upon "being able to take on meaningful and satisfying roles in society and gaining access to mainstream services such as housing, adequate personal services, education and leisure."

Recovery in action

Piers Allott articulated a similar vision to that outlined in *A Common Purpose*. He began by challenging the conceptualisation of recovery as a 'model', suggesting that it was more 'a way of being', characterised by hope, responsibility, information, collaboration, independence, action and reflection. "Recovery," he argued, "can be defined as a unique process through which a person, organisation, community or society owns their previous positive and negative experiences, takes responsibility for addressing issues arising from them, finds meaning in and works to take appropriate actions in respect of them, and does so to achieve a personal, organisational, community or society outcome and vision." A recovery approach, he continued, was focused on wellness (which meant more than the absence of illness), and "challenged both professionals and services to accede power to individuals and to provide them with the information, knowledge and support to manage their own experiences."

Karen Colligan, chair of Mind serving the citizens of Liverpool, Sefton and Kirkby, supported Piers' arguments, expressing shock at the "level of negativity" of some views expressed at the meeting, and highlighting the use of Wellness Recovery Action Planning (WRAP) as a vehicle for recovery processes conceived along these lines. "There are over 350 people across Merseyside who are living their lives according to WRAP," she said, "they are getting on with it and getting great benefit from it. They're 'driving their own car' so to speak without losing sight of the interdependency – they are living, sleeping and

breathing recovery. We aren't debating recovery, we are doing recovery." The WRAP approach is a good example of one form of recovery-based practice. It was initially developed in the United States by Mary Ellen Copeland who insisted on the centrality of hope, personal responsibility, education and information, self-advocacy and support for recovery. The service user is placed 'in the driving seat' in developing a WRAP that may set out what she wants to happen at times of crisis, life goals and the means of personal empowerment to realise these goals and have good quality of life (for more information visit Mary Ellen Copeland's site at http://mentalhealthrecovery.com/).

Another example of good practice discussed at the seminar was the adoption of recovery as the guiding star for mental health services in Devon and Torbay, including the training of 150 local workers in WRAP. Glenn Roberts reported that the Devon and Torbay Commissioners and Local Implementation Team (LIT) are committed to developing recovery-oriented services in fulfilment of their 'vision'. This process is supported by RecoveryDevon (www.recoverydevon.co.uk), a collaboration of local people interested in recovery-focused approaches, chaired by people with direct experience of mental distress.

The Devon and Torbay LIT's 'recovery statement' reads as follows: "Services will be delivered increasingly within mainstream primary and community settings. People who need services to be delivered in specialist facilities will be enabled to maintain and regain their health, wellbeing and support networks. These services will be based on the principles of recovery, self-help, early intervention, mainstreaming and social inclusion." (CSIP et al, 2007; p. 17)

What's the problem?

The vision articulated in *A Common Purpose* seems to be largely consistent with service user concerns and aspirations; it is about social models of mental distress, negotiated treatment outcomes and so on. So, what's the problem? What, if anything, should give cause for concern in 'official' versions of recovery – aside from the complaint that mental health professionals arrived late on the scene? Are service user activists, and campaigning organisations such as Mind, in the perverse position of lobbying for policymakers to take up the recovery idea, only to turn around and complain that these policymakers have stolen it when they do? And, why such intense and impassioned disagreement before, during and after this MindThink seminar when there appears to be plenty of ground for substantive agreement on a recovery vision and its desirability?

Well, it is important to be clear where disagreement is – and is not – located. No-one was critical of recovery tools like WRAP or DREEM, which place service users 'in the driving seat'. Everyone welcomed the increasing interest in social models of mental distress. What was evident was that there were conflicting assessments of the extent to which mental health services had in fact taken on progressive versions of recovery, and about the alleged political co-option of 'recovery'. In particular, there was criticism of its invocation in support of a welfare reform agenda that is viewed with concern and suspicion by many. At the most fundamental level, it may be the extent of the association of 'recovery' with ideas like 'personal responsibility', 'self-sufficiency' and 'self help' that is the key to divergent agendas.

Self-help and personal responsibility

A Common Purpose notes that concerns have been expressed that versions of 'recovery' imported from the United States have tended to reflect a distinctively North American set of values – notably, a rugged individualism and an emphasis on self-sufficiency. *A Common Purpose* provides a helpful corrective for rose-tinted and wild frontier versions of recovery, by reminding

"It's true that the value of recovery is clear and obvious. So why have service users had to lead the way on recovery? What took psychiatrists and other professionals so long? Why hasn't there been more research by psychiatrists on what helps people to recover. While recovery has been a core part of the empowerment journey of service users as a community from the start, it is only very recently that psychiatrists have finally got around to a statement on recovery."

Jan Wallcraft

"Recovery in this country would have moved forward far quicker if everyone had taken it on board. We are all responsible for not doing recovery, including the service user movement. The reality is that NIMHE has made considerable investment in involving service users and that where recovery has happened it is because people on the ground have wanted it for themselves."

Piers Allott

"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?' But there is a paradox. There seems to be a lot of agitation and concern when people with resources, power and authority pay attention and take things that service users pioneer on board. Don't service user initiatives want to influence and work with service providers and commissioners and policymakers? Or does the service user movement want to stay underground and in opposition? Where there is collaborative advocacy for recovery, as locally in Devon, there can be really positive change."

Glenn Roberts

us that "for some people who use services, independent living can be a lonely and isolating experience of living in a single room in a boarding house." (p. 13) At the same time, it does identify "personal responsibility" as a defining feature of its recovery vision. For example, it observes that "it is this shift from an entanglement or passive dependency on services to an 'active stance' of selectivity, thoughtfully and positively using treatment and services to support independence and self-management that characterises journeys in recovery for people with long-term conditions." (p. 7)

This is not an alien import that has been foisted on to the recovery agenda by professionals or policymakers. It (or something like it) is quite often a theme in service user narratives too. For example, Patricia Deegan – a US service user – in her seminal piece 'A letter to my friend who is giving up' wrote: "recovery does not happen to heroes through some secret fortitude of the heart. It happens for ordinary people like me and you, who, upon awakening, swing our feet over the edge of the bed and stand up. We stand up and look the day squarely in the face, knowing that today will not bring total relief from our pain. It means rather than despairing in the face of our pain, we seize the day with a fierce determination that only survivors know. It means that we head out for our supported work placement, or our TEP or our pre-vocational work unit. It means that we do this work with pride and that we are not ashamed." (Deegan, 1994)

This is an inspiring passage, and, of course, an active and empowered stance is liberating for people who have been treated as passive objects for professional intervention. But its sentiments can morph into the view that everyone experiencing mental distress is always able "to look the day squarely in the face," and this can then slide into something that is uncomfortably close to a general invocation to people experiencing distress to pull themselves together. In reality, a willingness to "swing your feet over the edge of the bed" will depend on what is on the other side of the duvet. For example, are there meaningful employment opportunities? What activities are available locally for people who are too unwell for work?

Another concern is that the long fight for recognition of all the amazing things that people can do has obscured the fact that mental distress can also be genuinely incapacitating – at least for some people and for some of the time. For someone with chronic and severe depression or agoraphobia or in the grips of a psychotic episode, the act of swinging their feet over the bed may be genuinely heroic – perhaps, in some circumstances, ill-advised.

> "The pressure that people are put under – from the Government, from mental health workers, from the DWP – is the pressure to conform … and we shouldn't be made to feel lacking, inadequate, useless, because of not living and behaving just like everyone else."

Shaun Johnson, a survivor activist involved with the Mind Link network, observed in his presentation that "we seem to have moved from services that expected people to stay permanently unwell to the opposite – and for many this is just as oppressive. If you have several mental health workers – and are being pressured from all sides on a consistent and regular basis to recover, or to recover faster – this can only have a detrimental effect on your mental state. You end up feeling guilty and inadequate. The pressure that people are put under – from the Government, from mental health workers, from the DWP – is the pressure to conform. To act normally – whatever that is – get off benefits, get a job, start behaving like everyone else. But, for many people, that isn't possible, or even desirable, and we shouldn't be made to feel lacking, inadequate, useless, because of not living and behaving just like everyone else."

There is also Rowland Urey's point about the need to recover from negative experience of the psychiatric system, which – however progressive it can sometimes be – has not always been empowering of people with mental health problems; for example, those subject to long-term institutionalisation and/or heavy use of psychiatric medication. For the 'system' (however transformed) to insist that these same people should be more 'self sufficient' and more willing to 'help themselves' might seem like adding insult to injury.

Individual experiences of the psychiatric system are crucial. For example, when Shaun Johnson was challenged by another participant about an apparently negative take on psychiatry, he responded that his attitude "may reflect the fact that I've seen 20 different locum psychiatrists in the last few years." Raza Griffiths, Joint Co-Ordinator of the Social Perspectives Network, commented that he found "it hard to square a lot of the discussion with my experience of services. All this stuff about hope, about constructing narratives… It just wasn't there. I was seen as a set of symptoms and managing those symptoms was seen as all about risk management. The language was all about doing bad things – about risk. There was nothing at all about empowering me to make that journey to recovery."

Agreeing with Jayasree Kalathil's call to record narratives of recovery from BME perspectives, Raza Griffiths said "we need to collect narratives of people who are recovered/recovering in order to inspire others and give hope that it can be done. Such a resource should also, however, include the stories of people who have disengaged from services in order to recover. They have a narrative too, and their voice needs to be heeded."

Day services – a sense of belonging or sitting around drinking tea?

In terms of practical service delivery, one manifestation of the recovery agenda has been increasing investment in services that are directed *outwards* and a disinvestment in traditional day services.

A presentation to the seminar painted a vivid picture of the impact on frontline third sector services – and, in particular, the presenter argued that there was a pervasive focus on employment services. "Within the current commissioning environment, the model is already hijacked," he reported. "Traditional day services are going down the pan. If you don't want to provide the employment-driven services that commissioners want, then somebody else will … the choice can be between supporting the views and needs of the people who use your services and surviving financially as a service in an increasingly difficult funding environment." The contract culture, he said, was a top-down one. Recovery had been "defined at the top" (largely in terms of mainstream employment) and everything was about the willingness of front-line services "to take on board the targets and measures set by policy processes that they have had little or no involvement in."

Alison Faulkner, a service user and freelance researcher, reflected further on these processes in her presentation. She commented that "the recovery approach seems to have taken us in an individualising and personalising direction," with a danger of "losing contact with the strength that people gain from each other, and the value of communities." This was, she suggested, "what day services are all about." However, she raised important questions about her own take on these issues. "In arguing for a continuing need for day service provision am I myself holding low expectations of people?" she asked, "Why am I saying that people need support from services like traditional day services? Is that my own low expectation? I think it is important to keep challenging ourselves about this." Part of her response to these questions was "to turn the focus back to communities and wider society … You cannot blame people for being what is called 'unhealthily dependent' on day services, if there is no source of solidarity and belonging for them in the community as a whole – ultimately, the challenge is to make society better by reducing stigma and discrimination."

Does something like traditional daycare provision have a role to play within a recovery vision then? Perhaps. But concerns were expressed that traditional day centres have too often provided only for a limited and impoverished experience of 'belonging' and 'inclusion'. This could itself serve as a barrier to a more authentic experience of inclusion ("a less institution-based form of institutionalisation" in the words of one participant). Perhaps a better conclusion would be that effective recovery services need to incorporate the kinds of supportive forums and safe spaces that are key features of the best day centre services – as a core dimension of an effective recovery approach. This is already the reality in many local Mind associations.

Employment – key to recovery or unhelpful obsession?

The biggest concern about the political adventures of the recovery concept was its association with what were perceived to be regressive changes to the welfare system and a narrow focus on employment as the holy grail of recovery.

There was agreement that many service users who are able and willing to work have been routinely denied access to employment by stigmatising attitudes and low expectations. It was also argued that many more people who currently do not work, would welcome employment if they were given help with battered self-esteem, suitable support over a decent time period and appropriate vocational opportunities. But there was also a widespread view that political reforms that dock benefits from people who fail to engage in 'work-related activity' are a significant step backwards. This is especially so when placed in the context of a stigmatising political discourse that is increasingly dominated by conceptions of 'work shyness' and the spectre of 'sicknote Britain'.

Mind strongly supports the arguments for meaningful work as an important component of recovery practice and has consistently championed the right to equal access to employment. At the same time, we have opposed the introduction of 'conditionality' into a reformed welfare system, and have serious concerns about the tone and trajectory of the welfare reform debate.

Developing his point about recovery being associated with paid work, one seminar participant argued that commissioning that claims to be driven by the recovery model is actually "driven by ministerial priorities with a big focus on social networking and employment schemes, such as Pathways to Work. For the Government, the recovery paradigm is about saying that most people with mental health problems would benefit from the new Pathways to Work programme. In fact, there is no evidence for this – and, for some of the clients with mental health problems that our service works with, this whole approach would be a disaster." The fear is that 'recovery' is being reduced to paid full-time employment without remainder.

> "There is a risk of losing the idea of what a meaningful occupation is – working is often too closely associated simply with competitive employment ...a lot of work environments can be unsuitable for people experiencing mental distress, and may actually make people unwell."

Shaun Johnson expressed this view in a particularly powerful and uncompromising form. He began by asserting that "many people with direct experience of mental distress are sick of the term recovery, because they see it as synonymous with oppression, with threat, with cuts in services, with fuelling stigma, and with dividing and ruling people with mental distress."

For government, the language of recovery was all about getting people back to work, meaning they could "cut off people's Incapacity Benefit and force them into soul-destroying, low-paid jobs. So what do the Government do? They move the goalposts at Incapacity Benefit medicals so that reports from GPs and the medicals themselves focus on the so-called positives rather than the negatives of being disabled. Thing is, the reason for doing that isn't to help and support that person but to cut off their benefit."

Thus the Government was using 'recovery' to shift the emphasis of public debate and policy away from help, encouragement and support, and as a means to justify cutting and limiting the welfare benefits people rely upon in order to live.

Concern was also expressed that work was being understood in an overly narrow way. Sarah Carr of SCIE expressed concern that "there is a risk of losing the idea of what a meaningful occupation is – working is often too closely associated simply with competitive employment. The arguments about work that seem to carry political significance often equate it with earning and paying tax. This neglects the reality both, on the one hand, that meaningful, fulfilling work can be therapeutic, and, on the other, that a lot of work environments can be unsuitable for people experiencing mental distress, and may actually make people unwell."

There is ample evidence that work can be an effective way to boost self-esteem and to develop social networks. But while work has the potential to deliver belonging, empowerment, hope and inclusion, this is in stark contrast to the more regressive and stigmatising aspects of current welfare reform, which can entrench separateness, stigma, despair and exclusion. And the wrong work at the wrong time can harm.

An agenda for moving forward

On reading the transcripts of this MindThink seminar it is evident both that there were areas of agreement (implicit or explicit) and of significant disagreement between key participants. It should be emphasised that there appeared to be broad consensus on key issues among most participants. The biggest apparent gulf was between some of the leading lights of recent work on recovery by professional bodies and statutory agencies and some participants articulating a service user perspective. This is a bit worrying.

Seeking consensus

But how substantial was this disagreement in fact? One recurrent theme was a complaint from champions of current recovery practice about the 'negativity' or 'pessimism' of some other participants. But the issues here may be factual, not indicative of disagreement about recovery principles or practice.

1. As a matter of fact…

There was disagreement about the extent to which mental health services had actually shifted to more recovery-oriented practice. These different perspectives seemed to reflect personal experiences of the mental health system, whether as a provider or service user. What is actually happening on the ground – and how optimistic or pessimistic we should be – is ultimately a factual or empirical question, so not an insuperable barrier to a common purpose or a collaborative way forward.

2. From my perspective

Another reason why some of the disagreements may have been more apparent than real was that a number of different levels or areas of policy and practice were run together under the rubric of 'recovery'. For example, the recognition that inspiring forms of recovery-based practice have developed in Devon or Merseyside and could be taken up more widely is entirely consistent with the expression of concerns about the co-option of recovery in support of the welfare reform agenda. And it is, of course, possible to be 'negative' or

"Clearly, recovery is a concept that is – by definition – amorphous and open to a range of interpretations. Equally clearly, it is only part of the picture. Certainly there are dangers of it becoming a brand, and particularly so if the government leaps on to it. Once a concept is taken up officially, it is a good bet that it will be defined and used in a way that won't reflect the understanding and values of people who framed it and need it. Sadly when bureaucratic organisations go for a concept they can spoil it."

Derek Draper

"I'm not sure what can practically be achieved by challenging official versions of recovery. The reality is that the train is already leaving the station, the policymakers have already colonised the concept and taken it over, and service providers are having to adapt in that environment. We can have a counterweight debate, but we also need to work to ensure the impact of this new government approach is as positive for service users as possible."

Seminar participant

"Recovery is about a critique of the mental health system which has been awful at enabling anyone to recover over the past 100 years … Service users are saying that there are many good individuals working in the mental health system and good things happening, but the bulk of professional practice and the way things have been organised has not promoted recovery."

Jerry Tew

"There is a basic problem in assuming that recovery refers to one thing – that there is or should be a unitary definition. That gets you into a competitive debate about whose understanding of recovery is correct. In reality, there are different accounts from many different viewpoints and it is important to value the richness of this diversity rather than pit them against one another in a way that creates unnecessary and unhelpful disputes."

Glenn Roberts

'pessimistic' about the latter and 'positive' and 'hopeful' about the former.

3. A bit of balance

MindThink seminars are consciously set up to provide open space for airing disagreement and promoting constructive debate about divisive issues. Participants' views might become less polarised with more space to articulate and develop them.

On the one hand, those who are most critical of the Government's welfare agenda – and of its impact on the commissioning environment – would probably recognise that there has been significant progress in developing more empowering, inclusive and recovery-oriented approaches by statutory agencies and professional bodies. Recent documents like *A Common Purpose* and *New Ways of Working* evince a mental health system that is developing a recovery-based approach. In addition, there have been promising government initiatives from the perspective of recovery-based practice, including progress on disability discrimination law, the establishment of the Equality and Human Rights Commission, massive additional investment in psychological therapies and some promising work on social inclusion.

On the other hand, those who were most positive about recovery-based practice would probably concede that there is still plenty of professional and institutional practice that is not at all conducive to recovery. They would probably acknowledge, too, that there are wider cultural, economic and social barriers to recovery. They would probably have concerns about aspects of current welfare reform initiatives and service-commissioning priorities.

A fundamental difference?

So, some of the apparent disagreement at the seminar may actually be quite superficial. But is it possible to discern a more fundamental point of difference that lay at the root of some of the more charged exchanges on the day? What is perhaps most striking is a distinction between individualistic/personal and structural/social takes on recovery – with the former stressing self-help, self-reliance and the independent actions of individuals and the latter placing more emphasis on structural obstacles to recovery and the need for collective action.

Both will surely have a place in an adequate model and approach, but different people will take different views of their respective significance.

This distinction may explain some heated exchanges about the role of the service user movement and the value of self-identification as a 'mental health service user'. Crudely, for those who viewed recovery in social and structural terms, a service user movement is an essential vehicle for achieving progressive economic, social and political change. For those taking a more ruggedly individualistic approach, identification as a service user could be seen as a barrier to moving on, and 'recovering' a life not defined by one's experience of the mental health system. More individualistic versions of recovery may also be more in line with the rhetoric of personal responsibility and self-help at the roots of a welfare reform agenda which – at its worst – appears to invite people who are unwell to pull themselves together and get to work (or else).

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Concluding points

Recovery is at the heart of Mind's vision for mental health. Mind advocates therapeutic approaches that empower individuals, enable them to be active participants in their own recovery, involve them in negotiation of treatment outcomes and which focus on what people are able to do. As an organisation, Mind is about hope, empowerment, inclusion, choice, diversity and belonging. This is as critical for our policy and campaigning work as it is for the service-delivery work of local Mind associations across the country. (Although – as one participant argued at this seminar – it can be difficult for local services to retain this focus in a commissioning environment increasingly driven by national political agendas, rather than by local need and front-line experience.)

From the perspective of the kind of social model of mental health articulated by Mind there are some clear limits to an exclusively individualistic take on recovery. Many of the barriers that still prevent people with direct experience of mental distress from living full lives are structural, and cannot be overcome by individuals alone – however positive, resourceful and determined. The recovery vision, as we understand it, cannot be realised without significant changes to professional practice, social attitudes, public discourses, cultural norms and assumptions, and economic and social structures.

There has been real progress, but we are not nearly there yet. The commitment and energies of service user activists will continue to be crucial in keeping up the pressure for progressive change, and ensuring it is informed by, and responsive to, the experiences and expertise of people who actually use mental health (and other) services. We also need to ensure we fully capitalise on a number of progressive initiatives to promote treatment outcomes that reflect service users' priorities and therapeutic processes that are not narrowly medical in focus, but orientated towards recovery in the fullest sense.

A related reason that recovery cannot be understood in purely individualistic terms is because it is also about an inherently collective process. This is the process by which service users as a group or community "find something they've lost and regain something that was taken away." As Rowland Urey argued, "it's not just about particular individual experiences of recovery, but also about collective and universal experiences of recovery. Service users describe themselves as survivors because it is a core part of their lives and identities within the mental health system caused by what Thomas Szasz describes as the 'colonisation of self as conscious thinking humans' – they know exactly where they're going because they never forget from where they came."

Some of Mind's commitments appeared to be more controversial than we had anticipated when we set up this MindThink event – although it is probable that some of the fissures would have narrowed considerably if we'd all kept talking, with more of a focus on areas of consensus. What seems critical is that this debate should continue. This seems entirely in line with the call for debate and discussion in *A Common Purpose*. That debate will only be 'open' and 'honest' if it is inclusive of, and responsive to, the sort of concerns about wider social and political trends and trajectories expressed at this seminar. Optimism cannot be a condition for participation in this discussion. In addition, if some professional champions of recovery see a service user identification as inherently problematic or doubt that service user activism has a continuing role … well then that is probably a discussion we should all be having too.

"On the one hand, government and services appear to have misappropriated recovery terminology to some extent. On the other hand, we have our own agenda, and we need to use whatever vehicles are at hand to promote it. We should not retreat from something that was hard won and extremely beneficial for individuals because its language has been appropriated for other purposes. Yes, we need to be alert to the risks of co-option, but we also need to keep faith with the original language and agenda."

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