



## *What is recovery?*

Recovery is "... a process, a way of life, an attitude... to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution" (Deegan, 1988; quoted by NIMHE, 2004a)

Its function is to "... [enable] people with mental health problems to maintain or rebuild valuable and satisfying lives within and beyond the limits imposed by their difficulties" (Repper and Perkins, 2003; quoted by NIMHE, 2004a)

The NIMHE Guiding Statement on Recovery suggests that the concept of Recovery merits "a broad definition" such as the return to a state of wellness after an episode of illness, the achievement of a quality of life which is acceptable and satisfying to the person after an episode of illness, and the process of gaining or restoring something. NIMHE also offers twelve 'guiding principles' for recovery which include cultural competence, consideration of a person's spirituality, inspiring hope in others, appreciating differences, involvement of a person's family and carers if the individual so wishes, and promoting inclusion. It is a term which has historically been used in the areas of physical disabilities and the treatment of addictions (Gagnon, 2004). For Anthony (1993) it is "the development of new meanings and purpose in one's life as one grows beyond the catastrophic effects of mental illness". Recovery focuses on a person's strengths instead of their deficiencies (Johnson, 2000).

Harding (1994) suggests that people who no longer receive prescribed medications, are working, relate well to family and friends, integrate into the community and behave in the kind of way that anyone would not detect they have ever received institutional care for a mental health problem – are 'recovered'. Deegan (1993; cited by Ralph, 2003) observes however that medication has formed an important part of her own process of recovery. Perhaps recovery means different things to mental health professionals, to administrators and to service users. NIMHE succinctly describes the recovery approach as the way in which "people are actively supported to acquire the skills, knowledge and strength to reduce the prevalence or harmful experiences in safe, simple and effective ways." (Purdy, 2003)

### ***What's new about it?***

The recovery model is perhaps not too dissimilar from the empowerment model

which according to Bush and Folger (1994; cited by Dugan, 2004) is “the restoration to individuals of a sense of their own value and strength and their own capacity to handle life's problems.” Evans (2000) asserts that in social care “Practice principles require social workers to be able to work in partnership with users in individual and family work, as well as in service development.” The Recovery Approach is heralded by medical professionals and service planners as a discovery akin to that of the New World. It can be argued that the fact that social workers have already been working this way for many years appears to have passed them by.

#### ***Where did it come from?***

The term Recovery did not begin to gain currency in literature about mental health until the late 1980s (Ralph, 2000). It largely originated as a concept in the United States of America and New Zealand (Allott, 2003) through the writings of service users and the success of twelve-step rehabilitation models (Allott, 2003). In the US it has taken root in the development of many state mental health services (Anthony, 2000), though it is also developing a uniquely British flavour (Turner-Crowson and Wallcraft, 2001; Allott, 2003).

#### ***Why all the excitement?***

- Recovery offers a fairer more equitable framework in which to work with users of mental health services
- It fits rather nicely with Government directives and guidelines (such as Modernising Mental Health Services 1998, the National Service Framework for Mental Health 1999, and the NHS Plan 2000) for the direction and the provision of mental health services to be led by or partnered with service users
- Anthony (1993) suggests that Recovery is the next stage of the development of global mental health services following on from deinstitutionalization, and the stage following that of community support and rehabilitation services

#### ***What does it mean to existing mental health services?***

- “A considerable paradigm shift that [includes] a movement away from a purely medical model” (Brown, 2003?, p. 35) – obviously only for services already practicing a medical model.
- Recovery calls for existing mental health services to “wholly reinvent themselves” (Jacobson, 1998; cited by Ralph, 2000).
- Mental health professionals and policy makers are required by the Recovery Model to re-examine and redefine their own professional identity and role and their relationships with service users (Ralph, 2000)
- providers of mental health services become accountable for the creation of a service environment which is orientated towards recovery (Ralph, 2000)

#### ***Is it appropriate for all types of mental health difficulty?***

Allott (2003) points to research which indicates that the recovery process is relevant to chronic conditions of mental illness such as schizophrenia. He acknowledges that outcomes are difficult to measure in this case due to what other writers have described as “the residual effects” of institutionalization. He

quotes research which asserts that recovery “is not a straightforward linear process”. Similarly experiences which psychiatrists define as psychotic are rather “a journey of contradiction and social compromise”, that is to say the person who has these experiences makes sense of them in their own (and the broader society’s) social context in a manner which may not always seem to others to be straightforward.

### ***I’ve heard about the Tidal Model. What’s the difference between the Recovery Model and the Tidal Model?***

- From the Tidal Model website: “The Tidal Model® is a philosophical yet pragmatic approach to the discovery of mental health.” It is a concept littered with metaphorical language at the same time as it is seeking to encourage people who experience mental health difficulties to describe their own experiences in their own language in order to make sense of it. The Tidal model emphasises how someone can *discover* (learn about) or *recover* (regain that which has been lost) their own mental health as a means of putting their lives into some form of meaning and context and as a “first step” to acknowledging their experiences.
- The Tidal Model can therefore be considered as being a *form* of recovery.
- The origins of the two models are also different. The Tidal Model was originally developed as an alternative model of mental health *nursing* practice and has since found support amongst the user movement (Barker, 1999). The Recovery Model has grown out of users’ own experiences.
- Davidson (2002) observes that whilst both approaches to mental wellness are similar, to date the Tidal approach has been mostly used in in-patient settings. This would imply that at present the Tidal approach is more specific than the Recovery approach which can be more adaptable to be used to direct services as a whole.

### ***Is Recovery cure or treatment?***

- there is a danger of professionals who modify language according to trends in health care of using the word ‘recovery’ to substitute for ‘cure’ (Davidson, 2002)
- in fact recovery is a process and not the end in itself (Boyd, 2000). It offers not so much an entirely new vocabulary but most vitally an entirely different way of looking at experiences of mental health. Therefore in recovery there is no such notion as ‘cure’ – one learns to manage one’s own experiences. There is no such notion as ‘treatment’ – one comes to acknowledge one’s experiences and to negotiate one’s way through them.

### ***PROS***

- Recovery has encouraged a shift in the locus of control from the treatment provider to the person who is recovering (Gagnon, 2004).
- Traditional mental health services have been autocratic and paternalistic, viewing people who experience mental health difficulties as disabled and as having continuous needs. Professional culture itself has assumed an

authoritarian posture to reflect this (ACCP, 2002)

- recovery is cost effective. As people recover they will become self-sufficient and require fewer services (Johnson, 2000).
- recovery as a concept is firmly rooted in the “profound realization” that people who experience mental illness difficulties are in fact human beings (Deegan, 1996; cited by Ralph, 2000)
- recovery encourages individuals to take responsibility for their own mental health and ultimately their own lives
- recovery offers a whole-systems approach in that it takes into account a person’s whole experience and seeks to regain and enhance it following a period of illness
- the recovery model offers medical care and medical professionals the chance for a radical shake up and shift of perspective which is perhaps long overdue
- recovery asserts that it moves the service user away from the burden of psychiatric labels conferred onto them by the service, and which are socially debilitating (Chamberlin, 1998)
- NIMHE asserts that mental health services which embody the recovery model will
  - focus on people rather than on services
  - monitor outcomes instead of performance
  - emphasise strength rather than perceived weaknesses
  - educate people who provide services (including the media) to combat stigma
  - encourage those who provide services to collaborate with those who need support instead of relying on coercion
  - by services enabling and supporting people to self-manage, and by promoting their autonomy, people will have less need to rely on formal services and professional assistance (NIMHE, 2004b)
  - in an era for all UK health care services in which government directives and guidance to health care providers emphasise partnership between services (Charlesworth, 2003) any model which encourages medical care to move towards the social care model (and cement partnership) is to be applauded
  - In a submission to the UK Government in reply to a consultation document about the draft mental health bill, the Sefton Recovery Group argues “we do not have mental health services in this country we have 'mental illness' services”). The focus of existing services is not helpful to people who experience mental health difficulties.

### **CONS**

- Recovery can be a vague and subjective process which has broad and varied definitions (Gagnon, 2004)
- “[it] has become the latest ‘buzz word’ in mental health circles” (Ralph, 2000; p. 6)
- Government and other funding bodies often require forms of treatment to be supported by evidence-based practices. This is problematical in the case of the Recovery process because it is personal, complex and often difficult to quantify (Gagnon, 2004).

- social workers have already been doing this for years in the form of the empowerment model. Arguably health academics have appropriated this model for themselves by giving it a new name.
- there is a danger that the notion of 'Recovery' is another example of the medicalisation (pathologisation) of a normal human process – in this instance someone's 'life-journey' -, a characteristic of medical professionals (Foucault, 1993)
- many users of mental health services insist that the term 'recovery' doesn't really describe their own unique journey through mental illness. One survivor of childhood sexual abuse complained that if recovery implies the return to something that someone was before their illness, they would rather not go back there (Ralph, 2000). Other words for Recovery which some service users prefer are healing, transformation, or overcoming (Ralph, 2000).
- some providers repackage their old model of services by prefixing titles with the word 'Recovery', and by using Recovery language (Ralph, 2000). Jacobson and Curtis (2000; quoted by Ralph, 2000, p.24) observe that such strategies indicate a lack of understanding of the concept of recovery, including an unwillingness to share power and responsibility with service users
- there is a mass of "language re-construction operatives" working in health care whose function it is to give old processes new terms. This ensures that "only the initiated can play the game" (Davidson, 2002). In the words of Szasz (1973), the medical professions retain their status as the 'new priesthood'.
- realistic service providers must ask themselves how viable the concept of Recovery can be within existing clinical and financial constraints (Jacobson and Curtis, 2000; cited by Ralph, 2000)
- recovery is a uniquely individual process which needs to be balanced against the system's need for standardization (Ralph, 2000)
- there are obvious implications of cost for services which "wholly reinvent themselves" towards a Recovery orientation
- Ralph (2000) admits that specific indicators of recovery have yet to be identified, but that there is "great interest in finding and using" such indicators (p.25)
- the necessity of finding a tool by which to measure recovery may give the mental health system a way to withdraw services from people who by that standard are 'recovered' (Ralph, 2000)
- Advocates of both Tidal and Recovery approaches are resistant to them being described as a 'model' because this inevitably leads to their systematization and medicalization. That such a method as the Tidal approach can be called a model is to create an illusion that it is static and fixed. The same applies to the Recovery process (Davidson, 2002).
- The system of self-help particularly advocated by service users such as Mary Ellen Copeland seems at first to best suit the experiences of white, middle class people who are sufficiently socially adept and articulate to both comprehend and action the self-help model. This is ironic when one of NIMHE's guiding principles is that of cultural competency (Principle number 3) (NIMHE, 2004)

- 'Recovered' can be as much of a 'label' as any other psychiatric diagnosis or definition (Ralph, 2000). We must examine who uses the term. The idea of 'recovered' can be said to bear a close resemblance to Foucault's concept of the 'medical gaze' by which medicine (and the medical profession) defines the individual (user of a service) by the way in which it regards them (Foucault, 1993, 1995)
- Allott (2003) refers to 'pragmatic defence mechanisms' such as smoking, the choice to work or not to work and stimulation-reduction, which help people to manage their experiences. The repudiation of these very mechanisms is precisely what Mary Ellen Copeland has placed in her wellness recovery toolbox which she claims to be a collection of tools to which the individual can resort to help manage their recovery
- recovery relies on such concepts as 'Hope' and 'life journey' which are somewhat metaphysical in tone and therefore problematical to define. Other recovery terminology is evidence of the increasing use of holistic philosophy in the assessment of a person's mental health and the influence of existentialist ideas to inform perceptions of mental health and psychiatry (Reed, 1999).

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