

Thinking about recovery and well-being in a social context

Recovery has often been defined as a “personal” journey (see Anthony, 1993). The concept itself rose from the work of people who have themselves experienced the challenge of rebuilding their lives with mental health challenges (see e.g. Chamberlin, 1977; Deegan, 1988). However, many have described a professional “take over” of the concept and the way in which it supports a politically neoliberal agenda (Perkins and Slade, 2012; Rose, 2014). Too often, problems are located within the individual and it is seen as the individual’s responsibility, to find hope, take back control over their life and access opportunities they value: the social, political and economic context of recovery and all the discrimination and oppression that people face are minimised or ignored.

“Wellbeing” is another construct that risks the same fate, as has the concept of “resilience”. Too often, poor health (physical and mental) are attributed to “life-style choices” that the person has made: if only we stopped our lives of indolence – the lack of exercise, smoking and drinking that lead to idleness and obesity – and followed the “five ways to wellbeing” then our well-being would be assured. Similarly, “resilience” is too often seen as the personal strategies that a person has developed for coping with the vicissitudes of life. Both emphasise “personal responsibility”. The social determinants of health, well-being and resilience (like having a decent place to live, friends, a partner, a family, the chance to do the things you value, a good job, etc.) and community though well documented (see Marmot, 2015) receive but scant attention.

Neither “recovery” nor “well-being”, nor “resilience” occur in a vacuum: they occur in the context of a family, a community, a culture, an economic, social and political environment. These go a long way in determining values and aspirations, the meaning of the challenges that a person faces as well as the resources and possibilities for rebuilding a meaningful, valued and satisfying life, as well as maintaining health and well-being.

This is not to say that individuals cannot change, or that personal responsibility has no role:

[...] personal responsibility should be right at the heart of what we are trying to achieve. But people’s ability to take personal responsibility is shaped by their circumstances. People cannot take responsibility if they cannot control what happens (Marmot, 2015, p. 51).

Poverty, unemployment, loneliness and poor (or no) housing are not a “life-style” choice. They are circumstances in which a person is deprived of control over their life and their possibilities for taking “personal responsibility” are severely constrained.

In this context, if services are to promote recovery and well-being we must first review their purpose: from “getting rid of problems” to enabling people to “get decent lives”. Indeed, surgeon Atul Gwande (2014) argues that this should be the primary purpose of health and social services:

We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being – and well-being is ultimately about sustaining the reasons one wishes to be alive [...].

Medicine must shift from a focus on health and survival to a focus on wellbeing – on protecting, insofar as possible, people’s abilities to pursue their highest priorities in life (Gwande, 2014, p. 7).

This is not dissimilar to the New Zealand definition of recovery “living well in the presence or absence of one’s mental illness” (O’Hagan, 2012, p. 1) which encapsulates both recovery and well-being.

Second, services need to think about shifting the balance of their efforts. Move from changing individuals so that they fit in, and a focus on “personal responsibility, to changing their circumstances and creating inclusive communities that can accommodate all of us: communities in which everyone can participate as an equal citizen. From an “I” society to a “we” society. Too often, when we think of “we” we think of “people like me”. Such “identity politics” has been really important in identifying and fighting oppression, prejudice and disadvantage. However, as an organising principle for communities it leaves much to be desired. It risks creating warring sects of like-minded people who have little contact with, or understanding of, each other. It requires people to identify themselves in terms of an overarching, defining characteristic (e.g. mental health service user/survivor) and obscuring other identities and roles. Just as in the old asylums, the identity of mental patient risks eclipsing all other facets of identity and personhood. Most people have multiple roles and identities (see Fanshawe and Sriskandarajah, 2010). The real challenge is to create communities that accommodate and celebrate diversity and enable people to inhabit multiple roles and identities. To understand individual recovery and well-being, we must understand this rich complexity.

If services are to better assist people in their journey of recovery and promote well-being and resilience we need both to address the social determinants of health and foster more inclusive communities.

The social determinants of health and well-being

Typically, advice relating to health and well-being adopts the clinical approach that is prevalent in health services. However, research relating to the underlying determinants of health and well-being derived from the field of public health tells a very different story. This contrast is amply illustrated Gordon (n.d.) of the Townsend Centre for Poverty Research at the University of Bristol who have contrasted the Chief Medical Officer’s “Ten Tips for Better Health” with alternative, evidence based, tips that consider the social determinants of health and well-being (Table I).

As Marmot (2015) observes:

Hard to argue with any of the first, public health, list; it is all very worthy, well-meaning, based on sound advice [...] and unlikely to make much difference. “I was about to drink and drive and have unsafe sex and then, just in time, I remembered the Chief Medical Officer’s advice”. “I was about to feed the children takeaway chips. But remembered the one about fruit and vegetables, so gave them a salad and fresh fruit instead”. “I’m worried about losing my job. Which probably means losing my flat, pretty stressful, but I make time to relax so it’s all right now”. The problem with the public health list is not that it is wrong – but that simply conveying advice is unlikely to lead to change in those who have most to gain (Marmot, 2015, p. 50).

Table I Ten Tips for Better Health

<i>The Chief Medical Officer’s Ten Tips for Better Health</i>	<i>Alternative Tips</i>
1 Do not smoke. If you can, stop. If you cannot, cut down	Do not be poor. If you are poor, try not to be poor for too long
2 Follow a balanced diet with plenty of fruit and vegetables	Do not live in a deprived area. If you do, move
3 Keep physically active	Do not be disabled or have a disabled child
4 Manage stress by, for example, talking things through and making time to relax	Do not work in a stressful low-paid manual job
5 If you drink alcohol, do so in moderation	Do not live in damp, low quality housing or be homeless
6 Cover up in the sun, and protect children from sunburn	Be able to afford to pay for social activities and annual holidays
7 Practise safer sex	Do not be a lone parent
8 Take up cancer screening opportunities	Claim all benefits to which you are entitled
9 Be safe on the roads: follow the Highway Code	Be able to afford to own a car
10 Learn the First Aid ABC: airways, breathing and circulation	Use education as an opportunity to improve your socio-economic position
Source: DoH (1999)	Source: Townsend Centre for International Poverty Research, University of Bristol

Source: D. Gordon (n.d.)

How many clinicians can honestly say that the people who use their services have really heeded their advice to stop smoking, and drinking, eat healthy food and get lots of exercise? Efforts to encourage people with mental health problems to stop smoking are not new, yet in England 40.5 per cent of adults with serious mental health problems continue to smoke (as compared with 14.9 per cent of the general population)[1].

In thinking about health (both physical and mental) and well-being, we need to move beyond encouraging people to adopt “healthy lifestyles” and address the social determinants. We know that, for example, loneliness is very bad for not only mental health but physical health. In their meta-analysis of the relationship between social relationships and mortality, Holt-Lunstad *et al.* (2010) showed that stronger social networks and social integration increases your likelihood of survival by 50 per cent. Social isolation is worse for your chances of survival than obesity, lack of exercise and alcohol and on a par with smoking:

Physicians, health professionals, educators, and the public media take risk factors such as smoking, diet, and exercise seriously; the data presented here make a compelling case for social relationship factors to be added to that list (Holt-Lunstad *et al.*, 2010, p. 14).

Similarly, the social determinants of health are also the social determinants of recovery. It is very hard to find hope, take back control over your life and access to opportunities you value if you are living in poverty, in a deprived area where crime is rife, with few, if any, friends and social contacts and where the prejudice and discrimination you face make social and economic participation difficult, if not impossible. Your ability to take “personal responsibility” is severely limited by your circumstances – unless we address these circumstances.

What does this mean for mental health practice? It means that we should spend as much, if not more, effort in changing a person’s circumstances as we take in changing the person. This might include, making sure that people have all the welfare benefits to which they are entitled, responding to government consultations that threaten to further disadvantage people living with mental health challenges, promoting social networks (including peer networks) in people’s chosen communities, challenging prejudice and negative stereotypes, helping people to access opportunities they value, using our influence to help people fight for better housing, etc.

Fostering inclusive communities

If recovery and well-being are about “living well” then, as Gwande (2014) says, this must include “sustaining the reasons one wishes to be alive” and a “protecting, in so far as possible, people’s abilities to pursue their highest priorities in life” (p. 7). This must centrally involve enabling people to access opportunities you value.

Being valued as an equal citizen is important to most people and this requires not only having access to opportunities that exist within communities, but also the right and opportunity to contribute to those communities. Always being on the receiving end of help and support from others is not, for most people, their highest priority or reason for being alive, and it can be a demoralising and demeaning place to be. Yet most mental health “care plans” focus exclusively on how people can get the help they need to resolve their problems rather than on the support they need to use their talents to contribute to their family, network and community. Work is obviously one way in which people can contribute to their communities (and have this contribution recognised and valued in the form of payment) and thereby become linked to their communities, and many people want a job. However, there are many other ways, large and small, of contributing to the life of your family and community (via, e.g. politics, art, contributing to the activities of faith communities and simply helping others out) and these may be equally important in promoting recovery and well-being.

The challenge is to move to a situation where people living with mental health challenges are valued citizens who are agents in their own lives, rather than being seen as the objects of pity, charity, health and care to whom things are done.

In order to promote inclusion and citizenship, the “clinical model” typically adopted within health services focuses on changing people so that they “fit in”: treatment and therapy to reduce disruptive “symptoms”, confidence building, skills training, etc. However, within the broader

disability movement, people with mobility and sensory impairments have long concluded that this approach has limited value in enabling people to live well as part of their communities. Instead they adopted a “social model” of inclusion which argues that people are not disabled by their supposed impairments but by the barriers they face in society:

It is attitudes, actions, assumptions – social, cultural and physical structures which disable by erecting barriers and imposing restrictions and limiting options [...] The social model of disability is about nothing more complicated than a clear focus on the economic, environmental and cultural barriers encountered by people who are viewed by others as having some form of impairment [...] (Oliver, 2004, p. 6).

Thirty years ago, Patricia Deegan, one of the pioneers of concepts of recovery recognised the parallels between her own experience of a diagnosis of schizophrenia and others who faced physical impairments (see Deegan, 1988). She too, argued that:

[...] having a psychiatric disability is, for many of us, simply a given. The real problems exist in the form of barriers in the environment that prevent us from living, working and learning in environments of our choice [...] [the task is] to confront, challenge and change these (Deegan, 1994, p. 9).

Disability activists have ensured that this social model is backed up by rights. At an international level, the right to participate fully in all facets of community life and the right to the support necessary to do this are enshrined in the United National Convention on the Rights of Persons with Disabilities (2006) and in the UN we have the Equality Act (2010). This not only outlaws discrimination (direct and indirect) but also requires that employers, education providers and the providers of goods and services to make “reasonable adjustments” to ensure access for people with the full range of impairments (including mental health challenges):

Inclusion and citizenship are not about “becoming normal” but creating inclusive communities that can accommodate all of us. Not about “becoming independent” but having the right to support and adjustments (in line with our choices and aspirations) to ensure full and equal participation and citizenship (Slade *et al.*, 2014, p. 14).

This type of social model of inclusion- and rights-based approach offers an alternative to a clinical approach that has proved highly effective in ensuring the greater participation in all facets of community life for people with a range of impairments, yet it has received relatively little attention within mental health services.

A social- and rights-based approach to inclusion requires us to think differently. To replace the question “what are a person’s problems and how can we get rid of these” with “what are the barriers (attitudes, expectations, assumptions, social, cultural and physical structures) and how can we get around these”:

- What sort of support might the person need? (the mental health equivalent of the wheel chair, the assistance dog, the sign language interpreter, etc.).
- What adjustments might the person need? (the mental health equivalent of the ramp, the hearing loop, signs in braille, etc.)
- How can we enable people to know and assert their rights?

Aids, adaptations and adjustments for people with physical impairments are relatively well developed and are primarily directed towards enabling people to access the physical world. Those for people with mental health challenges are less well developed and often need to be directed towards enabling people to access the social world.

Mental health services do not hold the key to inclusion and citizenship. Indeed, the presence of extensive professional services (both statutory and non-statutory) may mitigate against inclusion. As Mary O’Hagan has observed, such services tend to make individuals believe that they need professional help to put things right. Their nearest and dearest think that we are not safe in their untrained hands – better to leave it to the experts, and so our communities become less and less able to accommodate human distress. As Warner (2009) illustrates, it is noteworthy that outcomes for schizophrenia are better, and mortality for people with schizophrenia is lower, in the developing world where there are fewer professional services [...] but as such services are developing, so mortality is increasing.

However, it is possible that mental health services could become better catalysts in facilitating recovery, participation. To do this, we must “think beyond service land”, for example:

- Understanding people and their challenges and aspirations in the context of their community and culture.
- Moving beyond thinking about “the person in our services” (and what we can do to put right their problems) to thinking about “the person in their life”: where they have been, what has happened to them, where they are now, what they have got going for them, where they want to get to (and what help they need to use what they have got going for them to get from where they are now to where they want to be).
- Moving away from a focus on what we have to offer and considering people’s own resources and resilience (many have shown extreme courage and ingenuity to just keep going in the face of the things that they have experienced), their existing circles of support and the opportunities and resources available in communities.
- Helping the person to think about the support and adjustments they may need to do the things they value [...] and helping them to negotiate these and assert their rights.
- Recognising what already exists in families, social networks and communities and thinking about how we can learn from and support this.
- Supporting family, friends, people and agencies in communities: inclusion involves a relationship between the individual and their community and we need to think about supporting both sides of the relationship.

To conclude

There is a tendency for the concepts of recovery, well-being and resilience to be seen in highly individualised terms: a person must “take responsibility” for their own recovery and life-style choices and developing strategies for coping with the vagaries of life. This reinforces a neoliberal agenda and runs counter to the wealth of evidence that the social determinants of health, well-being, recovery and resilience.

Well-being and recovery are intimately interlinked. Recovery is about “living well”, pursuing your highest priorities in life, and both require that we have the resilience to cope with what life throws at us. However, these are not divorced from the personal, social and economic context we face. Our circumstances determine the extent to which we have control over our lives and can exert “personal responsibility”. The rebuilding of a valued and satisfying life that is the essence of recovery occurs in the context of a community, a culture, a material, social, economic and political environment which has a significant impact on our values and aspirations and the resources and possibilities open to us.

Mental health services must understand recovery and well-being in a social, cultural and community context. We must move from a primary focus on trying to change the individual to thinking about this context and how we can change the circumstances in which people live and create communities so that can accommodate all of us – including those of us who live with mental health challenges.

Note

1. <https://fingertips.phe.org.uk/search/smoking%20and%20mental%20health#pat/6/ati/102/par/E12000004>

References

- Anthony, W.A. (1993), “Recovery from mental illness: the guiding vision of the mental health system in the 1990s”, *Psychosocial Rehabilitation Journal*, Vol. 16 No. 4, pp. 11-23.
- Chamberlin, J. (1977), *On Our Own*, National Empowerment Centre, Lawrence, MA.

- Deegan, P.E. (1988), "Recovery: the lived experience of rehabilitation", *Psychosocial Rehabilitation Journal*, Vol. 9 No. 4, pp. 11-19.
- DoH (1999), *Saving Lives: Our Healthier Nation*, The Stationery Office, London.
- Fanshawe, S. and Sriskandarajah, D. (2010), "You Can't Put Me In A Box" *Super-Diversity and the end of Identity Politics in Britain*, IPPR, London.
- Gordon, D. (n.d.), *Alternative Tips*, Townsend Centre for International Poverty Research, University of Bristol, available at: www.bristol.ac.uk/poverty/healthinequalities.html (accessed 5 September 2018), reprinted in Marmot, M. (2015), *The Health Gap. The Challenge of an Unequal World*, Chapter 2, Bloomsbury, London, pp. 49-50.
- Gwande, A. (2014), "The future of medicine", Lecture 4: the Idea of Wellbeing, Reith Lectures, New Delhi at the India International Centre, BBC, available at: http://downloads.bbc.co.uk/radio4/open-book/2014_reith_lecture_4_delhi.pdf (accessed 5 September 2018).
- Holt-Lunstad, J., Smith, T.B. and Layton, J.B. (2010), "Social relationships and mortality risk: a meta-analytic review", *PLoS Medicine*, Vol. 7 No. 7, p. e1316, doi: 10.1371/journal.pmed.1000316.
- Marmot, M. (2015), *The Health Gap. The Challenge of an Unequal World*, Bloomsbury, London.
- O'Hagan, M. (2012), *Madness Made Me*, Open Books, Wellington.
- Oliver, M. (2004), "If I had a hammer: the social model in action", in Swain, J., French, S., Barnes, C. and Thomas, C. (Eds), *Disabling Barriers – Enabling Environments*, Sage, London, 376pp, available at: <https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/Barnes-implementing-the-social-model-chapter-2.pdf> (accessed 5 September 2018).
- Perkins, R. and Slade, M. (2012), "Recovery in England: transforming statutory services?", *International Review of Psychiatry Special Issue: Recovery Around the Globe*, Vol. 24 No. 1, pp. 29-39.
- Rose, D. (2014), "The mainstreaming of recovery", *Journal of Mental Health*, Vol. 23 No. 5, pp. 217-8.
- Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S. and Whitley, R. (2014), "Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems", *World Psychiatry*, Vol. 13 No. 1, pp. 12-20.
- Warner, R. (2009), "Recovery from schizophrenia and the recovery model", *Current Opinion in Psychiatry*, Vol. 22 No. 4, pp. 374-80.

Further reading

- Deegan, P. (1992), "The independent living movement and people with psychiatric disabilities: taking back control over our lives", *Psychosocial Rehabilitation Journal*, Vol. 15 No. 3, pp. 3-10.
- O'Hagan, M. (2007), *Parting Thoughts*, *Mental Notes*, Vol. 18 (Mental Health Commission), Wellington, pp. 4-5.