

We need to take account of the reality of the social oppression that hinders individual recovery journeys

the bigger picture

This is the first of a new series of comment columns from members of the Social Perspectives Network (SPN).

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Recovery promises a new direction in mental health thinking and practice that, instead of limiting people in terms of a clinical diagnosis, develops personal strengths, self-determination and hope for the future. This is surely a step in the right direction. However, recovery remains contested ground, and the degree to which service users will herald recovery as a new dawn will depend on how it is defined and applied in practice.

The potential for recovery to be narrowly defined as a journey back into paid employment to cut down on benefits payments is already worrying some service users. And fears around recovery are heightened for BME service users, who will need good arguments if they are to buy into the recovery agenda, particularly if it is determined by services they see as oppressive and irrelevant to their needs.

Will services really be able and willing to devolve power to service users, so that they can define what recovery is, what the recovery journey looks like, and what the milestones on the journey are? After all, much of the recovery literature does talk of the need to realign the professional establishment from controller to enabler.

If this were to really happen, then the drive towards very individualistic self-care, self-management and 'independent living' would have to be rethought, as it would not be an appropriate goal for those people – who would include many BME people – whose values are more geared towards community settings.

And, presumably, those service users who do not feel they have anything to 'recover' from and see their 'illness' as something positive would not be made to undertake the recovery journey at all but would be left to find their own truth. Conversely, recovery would not be used as a justification for cutting acute services and places of sanctuary on the grounds that recovery precludes episodes of acute illness.

A culturally relevant service user defined recovery journey might include reconciliation with spirits and jinns, or even involve exorcism/deliverance – issues from which many professionals shy away. The journeys would certainly need to be free from the racist stereotyping and discrimination with which services are riddled. The rubric of self-determination that is so central to the recovery journey demands that service users be enabled to take a creative risk every now and then, including African Caribbean men – something that is very unlikely to happen

now, when they are so stigmatised as being among the most dangerous of the mad fraternity. And self-determination would also entail the creation of culturally appropriate services and real choices for people from different backgrounds, for there can be no true self-determination without the ability to choose one's preferred path.

This is quite a tall order. The danger is that services will shy away from biting the bullet, and concentrate on developing outcome measures that are not suitable for people who are different, including BME service users. This will result in recovery becoming standardised and losing all its empowering and liberating potential. We will all have to go back to work, live independently, take our medication, and eat three shredded wheat for breakfast, in order to ensure that trusts meet their quotas for recovery. But nothing will be done to tackle the cultural illiteracy within services and racism that sometimes seriously undermine the recovery journey.

The reluctance of the establishment to give up power is signalled even in some of the more recent recovery writings, including *A Common Purpose* – the joint position paper on recovery from the Royal College of Psychiatry, the Care Services Improvement Partnership and the Social Care Institute for Excellence. SPN wrote the first draft of this often excellent paper, which champions recovery definitions that are mindful of diversity, but subsequent revisions allowed sentences such as this to creep in:

'People who use services can also misuse the concept of recovery or feel threatened by it. Some people who use services say that it is sometimes useful to appear to be "recovered" to get out of the system even though they have not recovered in any meaningful sense.'

This sentence comes over as an establishment interpretation and value judgement. Surely the first stage of recovery is to get out of harm's way, and this should also be recognised as a legitimate part of the recovery journey?

From a BME service user perspective, there is a lot of work to be done. We need to take account of the reality of the social oppression that hinders individual recovery journeys. This needs to be underpinned by social models of power and oppression that also take into account issues of diversity. Anything less would result in recovery rightly being dismissed as, at best, tinkering at the margins or, at worst, just another failed approach. ■