Chapter 1

Why Wellbeing and Recovery?

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This book brings together two bodies of knowledge.

What Is Wellbeing?

The first body of knowledge is concerned with 'a good life' – understanding what makes life worth living. Research into this topic is variously labelled as wellbeing, mental capital, positive psychology or positive mental health. These academic disciplines have a long tradition, certainly dating back at least 2,000 years to Aristotle's concept of eudaemonia – 'human flourishing'. However, as a scientific endeavour it has gained traction in the last two decades, in particular with the advent of the emerging field of positive psychology (Rusk, 2013).

Several theories have attempted to define and characterise key aspects of wellbeing. Self-determination theory, for example, emphasises the role of personal autonomy, competence and relatedness to others and the mechanisms by which meeting these requirements leads to autonomous motivation (Ryan, 2000). In contrast, the 'PERMA' theory of wellbeing asserts that five key areas constitute wellbeing: positive emotions, engagement, positive relationships, meaning and accomplishment (Seligman, 2011). The Foresight Report (subtitled 'making the most of ourselves in the 21st century') summarised the best available evidence on improving mental capital and wellbeing (Foresight Mental Capital Wellbeing Project, 2008). Its key messages were summarised by the New Economics Foundation as Five Ways to Wellbeing: connect, be active, keep learning, give to others and take notice (Aked, 2008).

Positive interventions demonstrate evidence of effectiveness: meta-analyses show that positive interventions have effect sizes around 0.3 (Bolier et al., 2013; Sin and Lyubomirsky, 2009), as outlined in Chapter 2. Wellbeing research has been increasingly widely applied, for example in organisations (Page, 2009) and in positive education frameworks for schools (Norrish, 2013). Governments are investing in positive assessment; for example, protective factors against trauma identified in wellbeing research inform the US$125m Comprehensive Soldier Fitness program in the US Army. Finally, wellbeing research has been applied to health settings, through positive neuroscience (http://www.posneuroscience.org), positive psychotherapy (Rashid and Seligman, 2013) and positive clinical psychology (Wood, 2010).

At the national level, the United Kingdom now has a Measuring National Well-Being Programme, run by the Office of National Statistics. The programme aims to produce accepted and trusted measures of the wellbeing of the nation – how the United Kingdom as a whole is doing. Population-level annual survey data are used to investigate how wellbeing is connected with relationships (Randall, 2015), social capital (Siegler, 2015) and many other areas

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of life (http://www.ons.gov.uk/ons/guide-method/user-guidance/well-being/publications/index.html). This allows international comparison of wellbeing indicators (Randall, 2014).

What Is Recovery?

The second body of knowledge is concerned with recovery in the context of mental illness. The notion of recovery has a long history in mental health services, traditionally understood as a 'return to normal'. A typical definition is that recovery involves full symptom remission, full- or part-time work/education, independent living without supervision by informal caregivers, and having friends with whom activities can be shared, all sustained for a period of at least two years (Libermann and Kopelowicz, 2002). However, in the past two or three decades a new understanding has emerged, which challenges the view that recovery involves a return to symptom-free normality. People personally affected by mental illness have become increasingly vocal in communicating what helps in moving beyond the role of 'patient'. Recovery has been defined as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles' and 'a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness' (Anthony, 1993).

The new understanding of recovery therefore places far greater emphasis on subjective experience, and is the meaning of recovery which is used in this book.

Implementing Recovery Is Challenging

The recovery approach has captured the policy ground internationally, as outlined in Chapter 3. Despite the international policy consensus, it has proved challenging to develop a recovery orientation in mental health services which gives primacy to the individual's understanding (Davidson et al., 2006). This is partly because the development of an empirical science of recovery lags behind policy. This mismatch is decreasing, as discussed in Chapter 3.

However, we believe that another reason that translating recovery policy into clinical reality has proved problematic is that a recovery approach remains embedded in a clinical perspective. However described, recovery is defined in relation to illness. This inadvertently reinforces a view of otherness – that even in a recovery-oriented mental health system, people with mental health problems remain different from other people. The empirical evidence supports this concern. Globally, high levels of experienced and anticipated discrimination are identified by people living with schizophrenia (Thornicroft et al., 2009) and other diagnoses, such as depression (Lasalvia et al., 2013). Stigmatising views are also present, and persistent, in health professionals (Henderson, 2014). Despite modest decreases in stigmatising attitudes in the wider community following national anti-stigma campaigns (Evans-Lacko, 2014), stigma in mental health staff and service users remains high.

Stigma creates problems. For staff, even those working to support recovery, it is hard to let go of the assumption that their need is primarily to deal with illness, that is to do things, ideally *with* but if necessary *to*, the service user. Care planning therefore involves actions primarily by staff, not service users (Gilburt et al., 2013). Illness-specific interventions are developed for everyday problems, such as social skills training for people wanting a relationship, or Individual Placement and Support for people wanting a job (Slade, 2012). Strengths of individuals are far less visible than deficits, so specific interventions are developed to assess (Rashid and Ostermann, 2009), amplify (Oades and Anderson, 2012) and orient services (Rapp and Goscha, 2006) to strengths. People living with mental illness continue to

live in social spaces defined by their illnesses, albeit the previous physical institution has been replaced by a 'virtual' institution (Priebe et al., 2005). A mental illness remains an 'engulfing' or 'enmeshing' identity.

The Intersection between Recovery and Wellbeing

The focus of this book is on the overlap between these two bodies of knowledge.

Wellbeing and the positive psychology literature have focussed on *living well*. Traditional mental health services have focussed on *getting rid of illness*. The overlap is very limited, because illness-oriented clinical discourse is irrelevant to the concerns of most people (who do not have an illness to 'get rid of'). The recovery approach, by contrast, focuses on *living well with illness*. The emerging scientific evidence about recovery therefore has implications for wellbeing in the wider community, and wellbeing research applies to people with mental illness.

The integration of ideas from these two disciplines is not entirely novel. The established and empirically validated two-factor model of mental illness and mental health is outlined in Chapter 8. The use of positive psychology research to support psychological recovery is described in Chapter 9. The aim of this interdisciplinary book is to enhance this rapprochement between these two bodies of knowledge, by

1. identifying the points of connection, where similar if differently named concepts have emerged within both disciplines;
2. using analogical reasoning to extend thinking, in other words, to speculate how a research finding about wellbeing in the general population may also apply to people recovering with mental illness, and how a research finding about recovery may have wider societal relevance.

One benefit of the scientific method is that ideas are made explicit, and hence amenable to debate. To illuminate some of the challenges arising from the use of academic knowledge to help people to live as well as possible, we outline some of the emerging criticisms of recovery.

Critiques of Recovery

A summary of international best practice in supporting recovery (described further in Chapter 3) identified four domains: supporting personally defined recovery; working relationships; organisational commitment; and promoting citizenship. The first three domains are being actively addressed. However, progress in the fourth domain remains elusive. Promoting citizenship involves living a life *beyond* illness, as a productive and contributing member of society. It overlaps with ideas around social inclusion (the term used in Europe and Australasia) and community integration (the term used in North America).

Critics of the recovery movement make the point that recovery as currently operationalised within mental health systems has several problems. It ignores issues of power (Morrow, 2012). It is political, maintaining neoliberalism (Braslow, 2013) and allowing continued denial of fundamental human rights (Forrest, 2014). Overall, recovery as a social justice movement has been hijacked by the mental health system (Mental Health "Recovery" Study Working Group, 2009).

This has led some commentators to link recovery with other struggles for power within society. In a wide-ranging book, Larry Davidson and colleagues show how recovery is linked to other social movements (Davidson et al., 2010). A recovery approach involves

fundamental changes in power, and thus links with other forms of identity politics (Slade, 2009). It involves a changed role for mental health professionals, from providers of treatment to political activists (Slade, 2010). However, power is rarely if ever given to groups – it is taken, through collective identity and empowerment. Historical examples include addressing racial segregation in the United States, obtaining voting rights for women in the United Kingdom and upholding rights for indigenous people in New Zealand and Australia. In relation to the mental health system, it is noteworthy that homosexuality ceased in 1974 to be classified as a mental illness not because of new scientific evidence, but because of protesters picketing the American Psychiatric Association's annual conventions.

Bill Anthony, in characterising the various approaches to defining and understanding recovery, proposed that they are united in their focus away from illness and towards personhood – his grandly named Transcendent Principle of Personhood summarised this as "People with severe mental illness are people" (Anthony, 2004). We have yet to witness the revolutionary phase of seeing people like us rather than people living with illness.

One approach to supporting this revolution is to envisage what it might look like. We believe that a mental health system that was fully supporting recovery would look different in language, assumptions, theory base and working practices. It would have a natural focus on strengths. The focus of worker actions would naturally be around the person's goals – there would be no need for specific technologies to support patient-centred care. Just as much attention would be given to society as to the individual, so rights, entitlements and responsibilities would be the common discourse, rather than management, treatment and risk. The organisation would be focussed on supporting access to mainstream solutions to everyday problems, with treatments provided as a means, not an end. The consumer would be in charge, deciding whether to use different types of support – so services would need to be customer-focussed to survive.

This might seem a far-off goal, but we are optimistic. Just as the idea that homosexuality could be just part of the rich tapestry of life must have seemed a distant dream fifty or a hundred years ago, so we envisage a society in which mental health problems are an acceptable and in some ways valued part of human experience. People will need help and support, either intermittently or continuously, but their mental health experience no more defines them than their sexuality, gender, personality or any other aspect of their identity.

Aims of the Book

This book has two aims. The mental health system is in the process of developing a deep understanding of recovery. The developing scientific evidence base of new technologies and approaches to support recovery has wider societal applicability. For example, the empirical evidence of benefit from the peer support worker role in mental health services has implications for other marginalised groups within society. The first aim of this book is to apply insights from recovery to the wider society.

The second aim is to consider what a mental health system would look like which started with the assumption that people with mental health problems are fundamentally like anyone else in society, with the same aspirations and goals. We believe that insights from wellbeing research – what everyone else needs for a 'good life' – are equally relevant to people with mental health problems. The aim is therefore to bring insights from wider research into the mental health system, by considering how mental health services should change if their goal is to support wellbeing.

The book is intended for an international readership. It will be of specific interest to two groups. Mental health service users, caregivers, workers and researchers will develop a better understanding of how wellbeing research can and should impact on clinical practice. Policy makers, researchers and community development stakeholders will develop a better understanding of how the methods of health services research illuminate some of the processes by which people with mental illness – and, by extension, other marginalised groups in society – can be supported to have lives worth living.

The book has three sections. In Section 1, contributors outline relevant theoretical foundations and conceptual frameworks for recovery and wellbeing. As noted, these are currently somewhat separate, so Section 1 makes linkages. In Section 2, contributors identify what mental health services might look like if wellbeing research is drawn in. In Section 3, contributors describe the implications of recovery and wellbeing research and related practises for the wider society.

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