Recovery and medication: not quite a revolution

COMMENTARY

COMMENTARY ON… FROM TAKING TO USING MEDICATION†

Frank Holloway

SUMMARY

In this issue of *Advances*, Baker *et al* describe a 'recovery-focused approach' to prescribing. They believe that there is a need for a paradigm shift in psychiatric practice. This commentary offers a brief introduction to the 'recovery' literature and a sceptical analysis of this bold claim.

DECLARATION OF INTEREST

None.

The article by Baker and colleagues (2013, this issue) is the latest in an informal series in *Advances in Psychiatric Treatment* that has explored the contemporary discourse surrounding 'recovery' within mental healthcare. These publications date back to a seminal and much-quoted article in this journal by Roberts & Wolfson (2004), which remains the clearest description to be published in the UK of the attractions of what was then termed the 'recovery model'. (Baker *et al* use the terms 'recovery agenda' and 'recovery approach', which are perhaps less prescriptive than 'recovery model' and certainly currently more favoured among advocates of 'recovery'.)

Recovery in the literature

There is a huge and ever growing literature on recovery, which has been well summarised by Slade (2009a). Slade's book carried an endorsement from Larry Davidson, doyen of the academic recovery fraternity, stating that 'the recovery revolution is sweeping the globe and the UK is no exception'. It is certainly having an impact in the British Isles: the term 'recovery' features prominently in official policy documents produced in England (e.g. Department of Health 2001; National Institute for Mental Health in England 2005), Scotland (e.g. Scottish Executive 2006) and Ireland (e.g. Mental Health Commission 2008). Non-statutory agencies in the UK have produced influential reports advocating recovery (e.g. Future Vision Coalition 2008; Shepherd 2008; Slade 2009b).

Core concepts of recovery

Assiduous readers of *Advances* will have noted the extension of recovery into the on-the-face-of-it unpromising areas of dementia, detained patients and patients in forensic settings (Roberts 2007, 2008; Hill 2010; Dorkins 2011; Roberts 2011). A joint publication from two large mental health trusts in London provides a position statement from consultant psychiatrists that rather neatly identifies three core concepts underlying recovery: hope, opportunity and agency (South London and Maudsley NHS Foundation Trust 2010). It also adds learning disability services, child and adolescent mental health services and addictions psychiatry to the recovery mixture (historically, the concept of recovery owes much to the addictions field).

The 'recovery model' *v.* the 'medical model'

Roberts & Wolfson (2004, p. 40) summarised their views of the differences between the 'recovery model' and the 'medical model'. In stark contrast to those embracing the recovery model, practitioners working within the medical model are, to paraphrase, not interested in the person (as opposed to the presumed mental disorder), their biography and their understanding of the meaning of what has been happening to them. Medical model practitioners work in an (apparently) value-free way, as opposed the value-centred 'recovery model', and are scientific rather than humanistic. Slade (2009b, p. 6) has adapted and expanded this analysis, offering 24 comparisons between the 'recovery approach' and the 'traditional approach', which include antitheses between 'understanding' and 'description', 'empowerment' and 'passivity', and 'choice' and 'compliance'. It is clear that the good guys choose recovery, although it is less clear that the medical model or traditional approach are anything other than straw men put up by proponents of recovery so that they can be knocked down with ease.

No one of good will could possibly be against instilling hope or fostering opportunities and,

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perhaps most fundamentally, a sense of agency for people living with mental illness. It is hard to see who could be in favour of disempowerment and against choice, who could deny the importance of the lived experience of people in, often very conflictual, contact with mental health services and who could not wish for ready availability of psychosocial interventions.

The semantics of 'recovery'

So, given its face validity, high-level backing and policy primacy, what's not to like about recovery? In fact, dissenting voices are remarkably few: of the articles published on recovery in this journal, only two have been in any way critical of the concept and I wrote one of them (Holloway 2008). Oyebode's (2004) commentary on Roberts & Wolfson (2004) identified the problem of meaning when the term 'recovery' is used, noting the disjunction between the ordinary language understanding and the way in which the word was used by proponents of recovery. This worry has been confirmed by significant semantic shifts by proponents of recovery: is it a 'model', an 'approach', an 'agenda', a 'paradigm' or *sui generis*? Indeed, the term is used in such a heterogeneous way that it is sometimes difficult to be confident that the word has any meaning at all over and above inducing a certain smug satisfaction among the aficionados of recovery (perhaps 'recoveryistas?') and a slight stirring of unease among those who feel they don't quite get it.

Recovery and prescribing

Baker *et al* explore from a recovery perspective what one might have imagined was the last bastion of the medical model – prescribing. They acknowledge, perhaps slightly grudgingly, that psychotropic medication may be of benefit and rightly draw attention to its potential disbenefits. They advocate a process of shared decision-making with the person using medication as a 'co-investigator' in the treatment process, weighing the costs and benefits of treatment options (including, of course, no treatment). They describe a small qualitative study that identifies feelings that people receiving medication have about the process, which are often quite negative. They tell us that the treating clinician should be aware of, and work with, the explanatory model that the patient (my word here for the individual in contact with services) adopts. They also confirm that, at times of crisis when treatment is given compulsorily, 'workers' should continue in a dialogue with patients and take account of their wishes in making treatment decisions. These ideas are presented as insights derived from a unique recovery perspective and they conclude that a recovery-focused approach to prescribing requires a 'paradigm shift' (a posh echo of Larry Davidson's 'recovery revolution').

Putting 'recovery' into perspective

This is good rhetoric, although perhaps less good intellectual history. There has most certainly been a change in the way that healthcare professionals interact with their patients (and indeed the public) over the 35 years since I qualified as a doctor. There has been a welcome long-term shift from paternalism to collaboration, particularly in the context of long-term conditions. General Medical Council guidance (2008) makes crystal clear the need for this collaborative approach to treatment decisions from doctors working in all specialties. Why and how this shift has occurred across medical practice is clearly complex but equally clearly does not flow from the recovery movement.

Putting the recovery rhetoric to one side, Baker *et al* make some sensible points. The concept of 'co-investigator' is a useful one, which is regularly deployed by the experienced clinician in discussing approaches to addressing the unique issues that an individual patient is experiencing. That decision-making should be shared is an ethical imperative. However, this is stretched to the limit when the patient lacks capacity or treatment is enforced, which is not, pace Baker *et al*, a rare event (excluding patients on a community treatment order, there were in the year 2010–2011 almost 50 000 compulsory admissions in England). Co-investigation and shared decision-making are entirely compatible with compulsory treatment in the hands of sophisticated practitioners, who will not uncommonly support trials off medication and very commonly work with patients who choose to stop medication or use it intermittently. Sensitive and collaborative use of medication is an important tool in the psychiatrist's armamentarium. Time perhaps to postpone the revolution and get on with what is for professionals, patients and carers the difficult task of minimising the impact of mental illness on one's life chances.

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IN OTHER WORDS

'I recall the advent of a new attendant...': extract from *A Mind That Found Itself*, by Clifford Whittingham Beers

Selected by Femi Oyebode

I recall the advent of a new attendant – a young man studying to become a physician. At first he seemed inclined to treat patients kindly, but he soon fell into brutal ways. His change of heart was due partly to the brutalizing environment, but more directly to the attitude of the three hardened attendants who mistook his consideration for cowardice and taunted him for it. Just to prove his mettle he began to assault patients, and one day knocked me down simply for refusing to stop my prattle at his command. That the environment in some situations is brutalizing, was strikingly shown in the testimony of an attendant at a public investigation in Kentucky, who said, "When I came here, if anyone had told me I would be guilty of striking patients I would have called him crazy himself, but now I take delight in punching hell out of them."

I found that an unnecessary and continued lack of outdoor exercise tended to multiply deeds of violence. Patients were supposed to be taken for a walk at least once a day, and twice, when the weather permitted. Yet those in the violent ward (and it was they who most needed exercise) usually got out of doors only when the attendants saw fit to take them. For weeks a ward-mate – a man sane enough to enjoy freedom, had he had a home to go to – kept a record of the number of our walks. It showed that we averaged not more than one or two a week for a period of two months. This, too, in the face of many pleasant days, which made close confinement doubly irksome.

Clifford Whittingham Beers (1876–1943) published *A Mind That Found Itself* in 1908. It is an autobiographical account of his psychiatric hospital admission and the abuses that he suffered during his treatment in hospital. In 1909 he founded the National Committee for Mental Hygiene (a reforming organisation), now renamed Mental Health America, and in 1913 he started the Clifford Beers Clinic, the first out-patient clinic for the mentally ill in the USA. This extract is from *A Mind That Found Itself: An Autobiography*, University of Pittsburgh Press, 1908: p. 136.

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