CREATIVE PRACTICE AS MUTUAL RECOVERY IN MENTAL HEALTH

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Introduction

This paper discusses how creative practice in the arts and humanities might promote the kinds of connectedness and reciprocity that support 'mutual recovery' in terms of mental health and well-being. The idea of 'mutual recovery' extends out of the increasingly influential notion of 'recovery' in mental health care, which refers to the possibility of achieving a meaningful and more resilient life irrespective of mental health 'symptoms' or disabilities. Typically, however, recovery-based initiatives tend to focus exclusively on people identified as having mental health needs (service users) and overlook how hard-pressed informal carers and health, social care and education personnel may also need to 'recover' or be 'recovered' in terms of their own mental health and well-being. Our central hypothesis is that creative practice could be a powerful tool for bringing together a range of social actors and communities of practice in the field of mental health, encompassing a diversity of people with mental health needs, informal carers and health, social care and education personnel, to establish and connect communities in a mutual or reciprocal fashion to enhance mental health and well-being. This approach is congruent with a 'new wave of mutuality' marked by 'renewed interest in co-operation' (Murray, 2012). Such an approach would add a new dimension to the growing field of health humanities (Crawford *et al*., 2010).

Background

The biggest change in mental health care, the de-institutionalisation and closure of the large mental hospitals, once heralded as a humane and technical revolution, has had a rather mixed

result. Concerns remain about how much this has contributed to improved mental health of society, with reports of increased social isolation and social exclusion, and higher rates of imprisonment. One outcome is that community care has been judged by some government ministers as a failure, not least Labour Leader Ed Milliband who has vowed to overhaul mental health services (The New Statesman, 2012). Together these challenges and responses have undermined service user trust in professional care and contributed to a growing public and professional scepticism about the effectiveness of mental health services (e.g. Schizophrenia Commission, 2012) together with a decline in the perceived capacity of therapists to identify and manage risks or create resilience, and tensions between law and mental health care (Bentall, 2009).

The size of the problem facing society is clear, with a growing burden of mental illness. Meta-analyses of sample survey and epidemiological data in Europe (e.g. Wittchen *et al.,* 2011) put incidence of mental illness in the population at nearly 1 in 3, whereas in the US National co-morbidity study elicits a lifetime figure of nearly 1 in 2 (Kessler *et al.*, 2005). Mental illness accounts for 19.5 % of all disability-adjusted life-years (DALYs), 40% of chronic illness and is the second greatest financial and social burden after cardiovascular disease. Suicide is second only to traffic accidents as the cause of death among those aged 15–35 years in Europe (World Health Organisation, 2005). 75% of prisoners in the UK have a diagnosable mental illness, with rates of psychosis in excess of 20 times the national average. These figures which emerged from the 1997 study of psychiatric morbidity (Singleton *et al.,* 1998) a situation which is believed to be even more acute nowadays (Appleby *et al.*, 2010). Overall costs of mental illness in the UK have grown from £77.4 billion in 2003, to £105.2 billion in 2009 (Centre for Mental Health, 2010). The response from the biomedical research community has been a renewed emphasis on biomedical and

neuroscience innovation, but with little confidence of success. The Medical Research Council (2010: 3) strategic report on mental health research notes "low research capacity coupled to the perception that the research questions in this field have been relatively intractable", which is combined with an ongoing scepticism in some quarters as to the value and effectiveness of exclusively pharmacological approach to mental ill health (Barker and Buchannan-Barker, 2012; Healy, 1999, 2012; Kirsch, 2009).

The crisis in mental health care is fertile ground for innovation, and the recovery movement has grown rapidly and vocally to fill the gap as part of a growing interest in self-help and a reaction to the perceived weaknesses of public mental healthcare (Beresford *et al.*, 2010; Davidson *et al.*, 2010; Repper and Perkins, 2003). Alongside this has arisen the growing influence of consumer-oriented, the civil and disability rights movements and, in the mental health arena, the rising power of the survivor movement. These have all asserted the rights of people with disabilities to live full lives, to have access to employment, education and full citizenship; in short, they have the right to support so that they can recover their lives – even if their mental health problems cannot be eradicated. This 'recovery' approach has now spread throughout the world, including the US, New Zealand and Australia, as well as the UK, and is under serious discussion in Europe (World Health Organisation, 2005). It is central to recent policy in the UK (DH, 2011), and is supported by professional, third sector and activist movements (Boardman and Shepherd, 2009; Shepherd, Boardman and Slade, 2008). There is a recognition of the need to redesign services to encourage resilience (Amering and Schmolke, 2009), and to address the difficulties expressed by service users themselves who stress that social context, such as housing, work, friendships and public attitudes are the key source of their difficulties. There is enormous energy behind this new 'recovery' approach, not dissimilar to that which transformed HIV/AIDS and physical

disability issues in the past: policy papers, articles, conferences are flourishing (Clements, 2012; O'Grady and Skinner, 2012).

In the face of a continuing and growing burden of mental distress, the second greatest financial and social burden after cardiovascular disease (World Health Organisation, 2005), a new paradigm for mental health care is appearing in many countries, which places the idea of 'recovery' in the foreground. Modelled on the US civil rights movement, and with its UK beginnings in the mental health service user and psychiatric survivor movement, recovery locates the difficulties of those experiencing distress in their social contexts, privileges the views of those who suffer, stresses the cultivation of resilience, and challenges the authority and expertise of traditional providers. This context means that 'recovery' is a contested concept in the field of mental health, with a key debate being whether it should remain a grassroots movement rather than something that is professionally controlled and administered. But either way, what we are seeing is the emergence of a new set of institutions, practices, identities, and discourses of 'recovery'.

Mutual Recovery

Importantly, the notion of recovering a more resilient life and cultivating positive social and cultural connections for mental health and well-being through mutual practices and relationships is something that has implications beyond people with mental health conditions or challenges, or experiencing mental health crises; this focus on mutuality, or reciprocity, means that the processes of recovery could have benefits for others involved. This could include those with more general wellbeing needs, informal carers and health, social care and education personnel (who are often themselves subject to high stress, mental health problems and burnout). Viewing recovery in this reciprocal way opens up new possibilities for

examining how recovery for mental health and well-being could occur through shared practice within and across these groups or communities, and how creative practice may assist such a mutual process. This relational ontology of recovery is important since it counters currently individualised conceptions of recovery within services and policy, instead seeing it as based around interactional processes, identities and social relationships. Mutual recovery is therefore a very useful term because it instigates a more fully social and deeper understanding of mental health recovery processes, encompasses diverse actors in the field of mental health, and attends to the need to track signs of wellbeing and improvement across this field.

Typically, divisions tend to exist between those with mental health needs, informal carers and health, social care and education personnel. What is rarely explored is how these groups can be brought together in and through the co-production of creative capital or resources in areas such as visual arts, music, dance, drama, literature/stories/narratives/reading, history, philosophy and the like, in order to forge stronger connections that can support mental health and well-being recovery and advance shared understanding. In community settings where helpers can be left isolated or facing a heavy burden or an increasingly demanding, production-line healthcare system (Crawford and Brown, 2011;Crawford *et al.*, in press), where threat looms large, and compassion fatigue is becoming all too common (Crawford, 2011; Gilbert, 2009; Rothschild, 2006), there are mounting concerns about the mental health and well-being of informal carers (e.g. Pinquart and Sörensen, 2003) and health, social care and education personnel (e.g. Edwards *et al.*, 2000; Rudow, 1999) alongside people with mental health difficulties. In other words, the notion of a clear separation in terms of mental health and well-being between people with mental health needs, informal carers, and health, social care and education personnel has become blurred. It is time to extend beyond a reductive focus on recovery of particular patient groups and conditions and investigate ways

that informal carers and health, social care and education personnel can also be supported to develop wellbeing and resilience.

Such a project would need to embody a knowledge exchange approach through linking disciplinary areas and diverse community partners, encompassing guidance on social inclusion and empowerment from service user representatives. This would mark a radical shift in vision in approaches to mental health that could transform how people with mental health difficulties, informal carers, health, social care and education personnel work together and take new opportunities to build egalitarian, appreciative and substantively connected communities – resilient communities of mutual hope, compassion and solidarity.

New Communities

There a compelling need to interrogate the often reductive definitions of 'community' that have prevailed in the literature and in policy discourse so far, and develop an empirically-grounded analysis of communities which is both more embracing and which enables recognition of the different roles people might play in creative practice and in possibly achieving mutual recovery. We do not assume that 'community' is an uncontested term or that members of a particular community enjoy solidarity around a set of agreed concerns and priorities. Instead 'community' should be embraced as a problematic, sometimes dysfunctional and potentially disruptive space where assumptions may be challenged and new propositions emerge. Any research emergent new creative practices within the field of mutual recovery would need to address this in determining an understanding of health communities and potential benefits for all stakeholders.

What we are suggesting, therefore, is a move to critically reframing of recovery in terms of the possibilities for connection between key communities in the field of mental health practice, including community arts, adult community learning, service user/survivor and carer groups and organizations, and mental health workers in health and social care services. This could also promote connections between these communities and communities of scholars in arts and humanities and social and health sciences. A disciplinary mix and variety of community partners would broaden the range and application of any research and deepen the synthesis of findings. Such a programme would further advance new challenges to a policy and research funding focus upon a narrow biomedical model, despite limited evidence for the effectiveness of pharmaceutical, genetic, neuroscientific and psychologically based interventions (Bentall, 2009) and damning reports (not least Ombudsman, CQC) that highlight unsatisfactory or non-compassionate 'care'. The poor yield from these biomedical approaches in mental health and deterioration in care environments in mental health services (and elsewhere in the NHS) creates an unprecedented opportunity to re-think responses to mental distress and wellbeing through the arts and humanities. What is needed now is careful and sustained investigation of approaches based centrally on a conception of social etiology and the novel use of powerful social technologies, drawing on creative practice. This would promote a new era of 'mutual recovery' in the field of mental health that has the potential to transform service provision and practice.

Creative Practice

Arts and expressive therapies are well-established in mental health services and creative practice has documented potential for having a unique role to play in advancing mutual recovery in this context. Research has already demonstrated the importance of arts for

'recovery orientated mental health services' (Spandler *et al.*, 2007), how they provide ways of breaking down social barriers, of expressing and understanding experiences and emotions, and of helping to rebuild identities and communities (Devlin, 2009; Secker *et al.*, 2007; Brown and Kandirikirira, 2007). They can help to create the kind of 'compassionate' spaces (Spandler and Stickley, 2011), characterized by mutuality, trust, shared understanding and recognition (Lewis, 2012a) so needed for mental health recovery (Tew, 2012). Similarly, from a humanities perspective, there is increasing research, for example, on the health and social benefits of narrative/ life story/ oral history/ creative writing (e.g. Eakin, 2003; Grant *et al.*, 2012; Grant *et al.*, in press; Moya, 2009; Rofe, 2009; Rudick, 2011; Scotti, 2009; Staricoff, 2004; Stickley *et al.*, 2007) and bibliotherapy (in the widest sense of reading as a therapeutic or health benefitting activity) on health, including mental health and social wellbeing within recovery based contexts (e.g. Aldridge and Dutton, 2009; Brewster, 2007; Brown, 2009; Canadian Council on Learning, 2007; Davis, Tomkins and Roberts, 2008; Department for Culture, Media and Sport, 2009; Dugdale and Clark, 2008; Frieswijk *et al.*, 2006; Hicks, Creaser *et al.*, 2010; Hodge, Robinson and Davis, 2007).

The social connections involved in mutual recovery include the generation of trust, networks and relationships, while cultural connections include shared understandings, experiences and ideas – or learning. In the field of mental health, social and cultural connections and community belonging, generation or development can arise from opportunities for breaking silences in a supportive environment on socially taboo topics (e.g. domestic violence, substance misuse) which surround distress (see Lewis, 2012a). The connections achieved in these 'compassionate spaces' may then provide a springboard into other collective or 'community oriented' activities.

Adult community learning (ACL) programmes and community arts projects that aim to promote mental well-being are examples of such spaces (Lewis, 2012a, 2012b; Spandler *et al.*, 2007), while, as indicated above, the discursive context of arts and humanities practice may be particularly effective in facilitating mental health recovery. However, this 'targeted' ACL and arts provision may be more successful at developing 'bonding' social capital between those with common distress experiences than social connections that 'bridge out' to the wider community (Lewis, 2012a, 2012b; Spandler *et al.*, 2007). The use of arts and educational provision for therapeutic aims may also enhance its ability to deliver on its primary creative or pedagogical purpose (Ecclestone, 2004). Thus, there is a pressing need to investigate the parameters of mutual recovery through creative practice across different settings and discursive contexts so as to tease out what mechanisms work for whom in what contexts (and what may also be barriers, inhibitors or perceived dis-benefits).

Conclusion

Mutual recovery for sufferers from mental health difficulties and their carers involves gaining knowledge, developing efficacious coping strategies, and becoming a better advocate for oneself and for others. Mutual recovery also involves enhanced self-care, which O'Grady and Skinner (2012) see as being especially important to "both short- and long-term mental and physical balance" (p.1059). Hence, recovery involves finding new meaning and purpose in one's life and those of others, despite continuing mental health symptoms. The notion of recovery acknowledges that there may not be a complete cure for a distinctive 'illness'. However, it involves a refusal to be dominated by labels and defined by one's diagnoses, instead learning to live with conditions which are sometimes enduring and incapacitating, and a determination to take care of oneself when a condition recurs. The notion of mutual

recovery through creative practice is more than just a set of creative activities which are believed to have benefit. The idea is also a heuristic that can be useful to professionals and family members, as well as individuals with mental health problems themselves. In Arthur Frank's work on illness and recovery narratives he tells of the critical importance of stories.

> Seriously ill people are wounded not just in body but in voice. They need to become storytellers in order to recover the voices that illness and its treatment often takes away. . . . When any person recovers his voice, many people begin to speak through that story. (Frank, 1995, p. xii–xiii)

The implications of the notion of mutual recovery, aided by creative practice, will continue to expand in ever-widening ripples for researchers, sufferers and for others in communities adopting this approach.

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