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Recovery-as-policy as a form of neoliberal state-making

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Abstract

In this paper I provide an analysis of the implementation of “recovery” as a policy object and commitment in the UK. This can be situated as part of the New Labour government’s (1997-2010) reform of the NHS during the 2000s. Through a textual analysis of policy and legislation from this time I draw out a tension between contemporary ideals of choice and autonomy in healthcare and the specificities of a mental healthcare system in which psychiatrists are legislatively empowered to treat patients without their consent. In the UK, evidence continues to show that the most economically and socially disadvantaged members of British society are most likely to be detained under the Mental Health Act 2007. This paper provides an intersectional analysis of the ways in which policy, legislation and psychiatrization enact particular subjects as ‘failed’ citizens. Following Tyler (2010; 2013), I argue that these practices of exclusion and detainment are constituent elements of neoliberal state-making, which are discriminatory and unjust.

Keywords: recovery, mental health policy, mental health law, neoliberalism, detention.

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Introduction

The contemporary emergence of recovery as a conceptual frame, and as a set of practices and policy orientations, encapsulates on-going and inter-related debates concerning madness and its management. Recovery raises questions about what kinds of lives are liveable and how conditions for those lives might be achieved (Butler, 2004). The history of recovery has multiple threads and is still in process; it cannot be understood to belong to any particular moment or movement in mental health. It can be found in the eighteenth century moral treatment or psychiatric rehabilitation that Michel Foucault ([1961] 2001) so strongly criticised, in the campaigns of twentieth century mental health activists and psychiatric survivors, and in twenty-first century policy documents.

In my doctoral research into recovery, which provides the basis for this paper, I have found Dutch scholar Annemarie Mol's (2005) concept of *enactment* useful in articulating how there is no singular "recovery". Instead different kinds of recovery are brought into being through different social and material practices. Recovery is not one thing with multiple meanings. Rather, different practices bring different enactments of "recovery" into existence. This conceptualisation of recovery helps to elicit how not all enactments of "recovery" are equal. Because recovery is multiple, this entails relations of power; certain enactments of recovery will marginalise or obscure others depending upon the context (Moser, 2008).

Recovery has become a central feature of mental health policies in many countries, including England, USA, Canada, New Zealand, Scotland, and Australia, and it is beginning to emerge in other European countries.¹ As such, it is often referred to as the current

¹ According to Slade, Amering & Oades (2008), the following policies include a commitment to recovery-orientated mental health practice: Australia's *National Mental Health Plan 2003-2008* (Australian Health Ministers, 2003); *The Journey to Recovery – The Government's Vision of Mental Health Care* (Department of Health, 2001) in England; *Blueprint for Mental Health Services in New Zealand* (The Mental Health Commission, 1998); *A Vision for a Recovery Model in Irish Mental Health Services* (Mental Health Commission, 2005); and the New Freedom Commission on Mental Health's *Achieving the Promise: Transforming Mental Health Care in America* (2003).

international “buzzword” in mental health (see, for example, Clay, 1999; Bracken & Thomas, 2005; Craig, 2008). Academic recovery literature has proliferated, with papers found across journals relating to psychiatry, psychology, psychiatric rehabilitation, clinical psychology, occupational therapy and social work. Authors from different disciplinary and experiential backgrounds with different agendas writing about the phenomenon of recovery have observed that the concept elides a clear or singular definition (see for example, Davidson, et al., 2006; Le Boutillier, et al., 2011). In this academic and policy literature, this lack of conceptual clarity is represented as a “problem” that must be solved in order to facilitate the implementation of recovery in practice.

Since recovery’s uptake in UK mental health policy, key figures charged with its practical implementation have worked up and widely circulated their own definitions. These authors have addressed the “problem” of conceptual ambiguity by classifying different types of recovery. A notable example is Mike Slade, a clinical psychologist who leads the *REFOCUS on Recovery* study at the *Institute for Psychiatry* at King’s College, London, which is funded by the *National Institute for Health Research*. Slade (2009) has made the distinction between “clinical recovery” and “personal recovery”. Clinical recovery is defined by clinicians based on reduction of symptoms, whereas personal recovery is defined by the person who is recovering.² This example shows how recovery can be defined in such a way as to retain medical expertise and make individuals responsible for their own recovery. Those with access to material and institutional power have been able to use recovery’s conceptual ambiguity to realign recovery with current dominant biomedical models of mental health and illness. Social justice enactments of recovery, which advocate for demedicalized and

² In her brief history of the concept of recovery, Nora Jacobson notes that this ‘bifurcation of recovery’ (2004, p. 51) has been implicit in mental healthcare since the early eighteenth century when William Tuke, founder of the York Retreat (1796 – present), distinguished between patients who were cured and those who were recovered. For Tuke, ‘cure was what doctors did to patients; recovery was what happened to patients with the help of nature alone’ (Jacobson, 2004, p. 50). Later, during Kraepelin and Bleuler’s respective research into dementia praecox, the terms “[r]ecovered with defect” and “healing with scarring” (ibid.) were created to explain cases that did not fit with the prognosis of inevitable deterioration.

collectivist approaches to madness and distress, are variously marginalised, co-opted and re-scripted through struggles over the term's definition. Instead of the social change recovery-based rights activism sought to bring about, existing practices are merely tweaked and re-branded "recovery-orientated".

At best, then, we can assert that recovery is a site of contested meaning. At worst, it is a discourse implicated in the continued marginalisation, medicalisation and exclusion of "mad" people. There is a growing dissatisfaction with recovery amongst mad-identified and mad-positive scholars and activists who argue that a social justice enactment of recovery has been politically neutralised, taken over by the very institutions it sought to challenge, and used to negative effect in service-users' lives (see for example, Harper & Speed, 2012; Howell & Voronka 2012; Morrow, 2013; Morrow & Weisser 2012; Rose 2014; Trivedi, 2010). For several authors, recovery has become 'deeply embedded with both the economic and the social imperatives of contemporary neoliberalism' (Voronka & Howell, 2012: 5; see also Rose, 2014; Morrow & Weisser, 2012; Morrow 2013). However, although some work has sought to situate recovery in the neoliberal context (Morrow 2013; Poole 2011), there is still a need to further unpick this entanglement.

This paper contributes an account of the enactment of *recovery-as-policy* in the UK as a form of neoliberal state-making that is discriminatory and unjust, in that it is 'designed to fail' (Tyler 2010) some (notably ethnic minorities and/or people living in poverty) more than others. I present a textual analysis of mental health policy and law introduced by the New Labour government during the 2000s. I argue that recovery has been used to create a space through which to usher in increasingly regulatory and oppressive mental health legislation that 'produce and police social difference' (Lloyd, Mitchelson, and Burridge, 2012, p. 9). I begin by outlining the changes to the British National Health Service's (NHS) mental health system by New Labour. Their mobilisation of a discourse of modernisation and progress in

the documents outlining these changes obfuscates the proliferation of psychiatric- and state-power signalled therein. Ideals of choice and citizenship are then unpacked in order to illustrate how mental health services can be read as a state border, through which certain people are excluded. In spite of continued pronouncements that these changes were modern and better, I show that there is little new about a system that continues to repress and restrain impoverished people. I conclude by asking if the ensuing re-institutionalisation in mental health that followed New Labour's reform can be understood as part of a wider neoliberal global complex of detention, producing failed subjects through which to accumulate profit and control populations.

New Labour 'Modernise' the NHS

In 2000, under the leadership of Prime Minister Tony Blair, New Labour invested in reforming the National Health Service.³ The Department of Health published *The NHS Plan* (2000) pledging significant funds towards supporting changes to the NHS, ensuring it would be 'modernised from top to toe' (Department of Health, 2000, p. 9). The changes signalled in this plan were 'to give the people of Britain a health service fit for the 21st century: a health service designed around the patient' (Department of Health, 2000, p. 1). Key elements of this reform were: that the health service would be decentralised, devolving control to local providers whose performance would be assessed according to new National Service Frameworks; that health and social services would work together in order to address the social context of health problems and improve the overall health and wellbeing of the nation; and, that patients would be involved in shaping service development.

³ The National Health Service was founded in 1948 in Britain. Its central principles were: 'the health service will be available to all and financed entirely from taxation, which means that people pay into it according to their means' (NHS website, 2015).

In light of this reform, Julie Repper & Rachel Perkins (2009) announced that:

The concept of recovery in mental health captures the key elements outlined in government health policy: a focus on the individual and their wants, wishes and concerns; the inter-relationships between health and social facets of people's lives; the importance of choice and control; the importance of promoting wellbeing and social inclusion and helping people to live the lives they want to lead. (p. 4)

For these authors, the future that activists had been fighting for was here. This optimism that “things can only get better,” as the New Labour election soundtrack enthused, saturates the literary style of government policy of the time.⁴ There is an emphatic reiteration of words such as “new” and “modern” throughout, affirming the Labour party's novelty indicated in the name *New Labour*.⁵

In 2001, the Department of Health published a summary of the changes made to mental health policy for those indirectly involved with mental health services, such as the police or voluntary sector organisations. It was entitled *The Journey to Recovery – The Government's Vision for Mental Health Care*, an artful amalgam of the metaphors of maps and journeys in activist writings about recovery that assert expertise through experience (see for example Barker, Campbell, & Davidson, 1999; The Icarus Project, 2013) and William A. Anthony's (1993) famous assertion that recovery was the new “guiding vision” for mental health service provision in 1990s USA. In the Department of Health's (2001) document, however, this new ‘vision’ now belongs to the New Labour government (not to activists), and infers ‘statesmanlike foresight’ and imagination (OED, 2015).

⁴ The song ‘Things Can Only Get Better’ by pop group D:REAM (1993) was used by New Labour in their election campaign in 1997.

⁵ New Labour refers specifically to the years 1994-2010. The ‘New’ was removed from the parties name when Labour lost a general election to a coalition of the Conservative and Liberal Democrat parties.

In her foreword to *The Journey to Recovery*, then Secretary of State for Health Jacqui Smith details how the new investment of £700,000,000 in community mental health would ‘put right, over time, the neglect of mental health services in the past . . . [by] . . . modernising [them]’ (Department of Health, 2001, p. 1). A key element of this would be mental health and social services working more closely together. This locates modern mental healthcare *in the community* and situates the neglect that took place firmly within the asylums of the past. It also implies a broader understanding of the social factors involved in health. Smith’s brief introduction evokes criticisms of the medicalisation of distress and of institutionalisation. Nevertheless, Smith situates mental health as a ‘clinical priority,’ (ibid.) and the rest of the document continues to place psychiatric discourse at the centre of the system. Rather obliquely, Smith closes with the assertion that: ‘We have set out on the road to recovery’ (ibid.). Given the designated audience and the assertion that recovery is a clinical priority, it seems likely that the “we” Smith is referring to is the mental health system itself, which needs to find “new” and “better” ways of delivering its services.

In their introduction to the document, John Mahoney and Antony Sheehan, then joint Heads of Mental Health in the Department of Health, expand on the neglect of mental health services referred to by Smith. They assert that:

For much of the past hundred years, decaying, depressing old hospitals housed far too many people – often far from their homes – for long periods. Out of hospital, people with mental health problems received little or no help. (Department of Health, 2001, p. 3)

In this passage, it is not psychiatric practices which are deemed to be failed or flawed, but rather the institutions in which psychiatry was practised – the ‘decaying, depressing [and] old’ (ibid.) Victorian buildings that characterised the “great confinement” in Britain. The

picture Mahoney and Sheehan paint erases psychiatric practices from this history of neglect, and this continues:

In part, this has been due to misplaced attitudes. In the public mind, “madness” has too often been quite wrongly equated to “badness”. Society has shunned and excluded those affected, often denying them work, a decent chance in life, and respect.

(Department of Health, 2001, p. 3)

According to Mahoney and Sheehan stigma, the equation between mental illness and danger, and social exclusion may be the ‘legacy of large institutions’ (ibid.), but it is the public who have ‘misplaced attitudes’ (ibid.). There is no recognition that psychiatry *informs rather than reflects* public understandings of mental health (Campbell 1996).

The Journey to Recovery continually evokes a shameful history of large institutions and the failure of care in the community. A brief history of the mental health system in Britain is provided in the section entitled *A Century of Slow Progress* (Department of Health, 2001, p. 4) to substantiate the need for New Labour’s proposed changes. It states that the Victorian asylums were built with good intentions but quickly became ‘overcrowded and awful places’ (ibid.). By the beginning of the National Health Service in 1948, the asylums were little changed. According to the authors of this potted history, the discovery of ‘new, more effective, medication’ (ibid.) and the *1959 Mental Health Act* led to ‘people receiving care outside of the traditional hospital setting’ (ibid.), whilst ‘from the 1970s acute wards in district general hospitals offered an alternative to institutionalisation’ (ibid.). Finally, by the 1990s, they assert that the new system of community care was in ‘chaos’ (ibid.) There are repeated references throughout this brief history to both hospitals and the community being ‘bleak’, ‘neglected’, ‘shabby’, ‘depressing’, ‘awful’ (ibid.) environments for people with mental health problems. These are reiterated in concordance with the assertion that lack of

funds - ‘a cash-starved NHS’, ‘resources not always reinvested in mental health care’ (ibid.) – were primarily to blame for these desperate situations. This history justifies the government investment of a significant amount of funding into the mental health system, but, as I will show in detail below, it also justifies the retention of psychiatry at the heart of that system.

The framing of the mental health system as “in crisis” presented in *The Journey to Recovery* is both economic and ideological.⁶ As Voronka (2008) has argued, psychiatry ‘sits on a precarious credibility ... [requiring] constant re-legitimation in order to hold stable its assertions that madness is a problem of science and disease’. Indeed, psychiatrists themselves continue to debate their own discipline’s validity and practices (see for example, Bracken et al 2012; Oyeboode & Humphries 2011). *The Journey to Recovery’s* particular historiography of the UK’s mental health system is performative, legitimating a continued investment in a biomedical model of “mental illness”. The logic proceeds thus: If one believes that psychiatry is in “crisis” then it must change either by becoming more “scientific” or more “recovery-focussed,” and if the mental health system has been neglectful, then it must be “modernised.”

In using the metaphor of “recovery” to describe the modernisation of mental health services in “crisis”, policy-makers appear to listen to patient voices. However, the history of user/survivor activism is precisely silenced in this policy commitment. Their challenges to concepts such as ‘lack of insight’, their critiques of the medicalisation of distress, forced treatment and detainment, and their assertion of expertise by experience are eradicated. Indeed, as I will show below, the uptake of recovery-as-policy can be seen as a direct response to the challenges posed by user-survivor activism, in which the ‘relations of domination have been restructured’ (Lloyd et al., 2012, p. 5).

⁶ I am not proposing that these are distinct from each other.

The Empowerment of Psychiatry

The history provided by *The Journey to Recovery* details the transformation of the public mental health system from custody to medical care as ultimately empowering for patients. As I have shown above, the history presented moves from denigrating institutionalisation to advocating for psychiatric wards as the best alternative, and is therefore able to depict lack of hospital beds as problematic. The large public asylums of the Victorian era are therefore conflated with neglect, whilst lack of space within new psychiatric services is also found to be neglectful. The history of the mental health system presented in *The Journey to Recovery* therefore draws focus to the places of neglect (in asylums or wards or communities), but not the practices of psychiatry that activists have described as ‘state sanctioned torture’ (The Kissit! XX Campaign Against Psychiatric Assault 2006). This is because the government intended to strengthen these practices.

This way of telling the history of mental health services relies upon a false distinction between custody and care. What is missing from this account is how mental distress and madness came to be widely understood both as health problems that require medical intervention and social problems that require legislation. By exploring this, I offer a different perspective that shows this so-called “Century of Slow Progress” to be a story of psychiatric (and state/law) empowerment. In the name of recovery, then, many of the amendments indicated in New Labour’s reform were in fact extensions of existing practices and frameworks. This was achieved in three ways: first, madness and distress were re-affirmed as illnesses; second, coercion and detention continued to be framed as socially progressive, permitting the extension of coercion and control of patients; and third, the marketisation of healthcare promoted ideals of individual autonomy that work against collectivist and social justice principles, casting “mental illness” as a personal, rather than social, problem.

An Illness Like Any Other

Discourses of medicine and illness enable institutions such as psychiatry, law and government to represent madness and its treatment as transcendent of social inequalities. For example, the early twentieth century saw the *Royal Commission on Lunacy and Mental Disorder* recommend that psychiatry be recognised as a field of medicine, and therefore move from guarding the “mad poor” in squalid and crowded asylums to treating “mental illness” in hospitals (Crossley, 2006). The dispersal of psychiatry out of the asylum and into general practice was legislatively supported by the *Mental Health Act* (1959), which, crucially, removed the distinction between mental and physical illness (Bluglass, 1978). The effect of this legal move was to consolidate psychiatry’s claim that ‘mental disorder was an illness and should be treated as such’ (Busfield, 1997, p. 241). Whilst the ‘emerging concept of patienthood was seen as beneficial, and with a classless image’ (McCourt-Perring 1993, p. 31), these policy changes did more to establish psychiatric power than improve the social and economic conditions of the newly-termed patients.

The claim that madness is an illness like any other continues to be used today in campaigns against stigma and for further investment in mental health services,⁷ which are often described as the NHS’s ‘Cinderella service’ (Mitchell, 2013).⁸ However, the idea that biomedical theories of mental illness reduce stigma and address inequalities rather than perpetuate them is fundamentally flawed. For example, Daley, Costa & Ross (2012) have shown through a detailed analysis of psychiatric charts that biomedical psychiatric practices reproduce social inequalities rather than address them. This is one example of a wealth of scholarship examining the racialized, gendered, heteronormative, ableist and classed politics

⁷ See for example, *Whole-Person Care: from Rhetoric to Reality. Achieving Parity Between Mental and Physical Illness*, a report by the Royal College of Psychiatrists (2013) that was recently discussed in parliament, and Mitchell’s (2013) article concerning funding mental health services.

⁸ The class politics of this metaphor are particularly telling. Mental health services are the poor and unrelated relative of the physical/general medicine, and must spend time clearly up the household waste (read: patients?). For more on the global neoliberal human waste production see Tyler, 2013 and McWade, forthcoming.

of psychiatry (see for example Fanon [1968] 1972; Fernando 2010; Kalathil 2007; Mama 1984; Metzl 2009).

Mental Health Law as Socially Progressive

The authors of *The Journey to Recovery* state that new medication and changes to the law enabled deinstitutionalisation. In doing so, the authors represent mental health law as socially progressive. This compliments the idea that madness and distress are an illness like any other. In the 1950s a new *Royal Commission on Mental Illness and Mental Deficiency (the Percy Commission)* laid the conceptual ground for both the closure of all asylums (moving into a community based care service) *and* the legal right to enforce hospitalisation and treatment (Barnes, Bowl, & Fisher, 1990; Crossley, 2006). The Percy Commission's statement on how mental disorder interferes with a patient's ability to determine their own best interests "civilizes" a law that permits forcible treatment, and places the actions of those carrying out the law in the context of acting for the patient's own good . . . creating a new moral climate around the use of compulsion' (Barnes, Bowl, & Fisher, 1990, p. 16). Echoing this analysis, Pilgrim (2012) argues that '[f]or those adopting this view, whether professionals, politicians or their voting public, the very existence of 'mental health' legislation inherently represents a form of social progress' (p. 69). Pilgrim (2012) places 'mental health' in quotation marks to indicate that such legislation is not concerned with health but *disorder*.

A new Mental Health Act was passed in 1983 that gave the state further powers to legally detain and treat people with mental health problems without consent. By the 1990s, hospital closures meant that there were fewer beds available for patients. Thus beds became solely reserved for people being sectioned under the Mental Health Act, and acute psychiatric wards became 'holding units for risky patients' (Rogers & Pilgrim, 2010, p. 221). In response, the amendments to the Mental Health Act made in 2007 would address the "problem" of how to

control these patients in the community, by allowing treatment without consent to take place outside of the ward: ‘a version of this ‘long leash’ approach to the surveillance and control of non-compliant patients outside of hospital’ (Rogers & Pilgrim, 2010, p. 222).

Thus, the slow and gradual move to care in the community involved the ‘expansion by psychiatry into increasing areas of life, increasingly defining social deviancy as mental illness and emphasising control of symptoms’ (McCourt-Perring 1993, p. 33). This was represented as a socially progressive alternative to the total institution, which had become irrevocably stigmatised. The language of “health” is used to obscure the underpinning discourse of mental “disorder” in legislation; the net result being that enforced “care” is represented as in both the patient and public interest.

Individual Self-Responsibility

The Journey to Recovery indicates that one of the targets set for modernising mental health services is increased communication and partnership between mental health and social care organisations. However, the psychiatrisation of madness and distress relies upon the continued separation of these two areas. The move to care in the community, under Margaret Thatcher’s Conservative government (1979-1990), was facilitated by this distinction (see *The Griffiths Report* 1983, and *NHS and Community Care Act* of 1990). The ongoing splitting of health problems from social problems fitted neatly with their neoliberal free-market ideology, which entails a discourse of individual self-responsibility.⁹

Val Gillies has argued that neoliberalism ‘requires people to embrace their individualised citizenship and become ‘responsible risk takers’’ (2005, p. 837). For Gillies (and many others), the idea that the self-responsible citizen will flourish economically, culturally,

⁹ In his history of the NHS Charles Webster traces the beginnings of the neoliberal discourse of self-responsibility to the Labour government of the 1970s, who published *Prevention and Health: Everybody’s Business* in 1976, which accused the public of ‘bringing ill health upon themselves and thereby wasting the resources of the NHS’ (Webster, 1998, pp. 137-138).

physically, socially and psychically through taking responsible risks informs a culture of blame in which ‘poverty and disadvantage is associated with poor self-management’ (ibid.). This provides symbolic strength to the argument for marketisation in which the “burden” of those in poverty and/or living with illness or disabilities is no longer borne by “tax-payers.” This problematic distinction between people who are ill, disabled or unemployed and “hard-working taxpayers” as if they were different groups of people continues to feature heavily in Conservative politics today (Jensen & Tyler, forthcoming). In contradiction to the idea that illness is classless, then, the prevailing neoliberal socio-economic agenda frames madness and distress as consequent of irresponsible behaviours and choices that need to be controlled and contained. As I will show below, the enactment of recovery-as-policy fits well with this ideal of individual self-responsible citizen.

Ideals of Choice and Citizenship

I have shown that whilst heralding a new age of social inclusion and care in the community, mental health policy and legislation under New Labour actually entailed increased social exclusion coupled with increased compulsion and control of patients. The use of discourses of modernisation and patient-centred healthcare (recovery) served to both disguise this extension and make space for its implementation. Building on a history of medicalisation, legislation and marketisation, recovery-as-policy enacts psychiatric patients within a paradox in which the ideal of choice obscures increasingly repressive legislation that extends the powers of psychiatrists to detain and treat people against their will.

This co-option of recovery to reassert psychiatric power can be understood as a practice of ‘state building’ (Blitz cited in Tyler, 2010, p. 62) that involves ‘the revocation of the rights to citizenship’ (ibid.). The form of citizenship enacted in mental health policy and legislation requires autonomous and rational individuals that take responsibility for their own behaviour

by making the “right” choices. Because there are “wrong” choices, some individuals are ‘designed to fail’ (Tyler, 2010, p. 61) as citizens, and as regards British citizenship and mental health, statistical evidence reveals that Black and Black-British men “fail” the most (House of Commons Health Committee, 2013; Pilgrim & Tomasini, 2012).¹⁰ To further elaborate the enactment of recovery-as-policy in the UK’s mental health system, we therefore need an intersectional analysis of ideals of citizenship and choice enacted in mental health policy and law.

Autonomous Individuals

Jeannette Pols (2006) has shown that there are different enactments of citizenship and choice made possible in different mental healthcare practices. In her study within a psychiatric hospital in the Netherlands, she found that patients were given choices, but only as long as social norms and values were observed. In contemporary mental healthcare, she argues,

the first thing to be strengthened and developed is individuality and specific individual competences, *so that the individual may become sociable later.*

“Participation in the community” seems to imply the addition of new individuals who are taught how to behave, leaving the community “out there” to function as before. (2006, p. 98: emphasis added).

According to Pols (2006) becoming a citizen is enacted as a matter of choice in which an individual’s capacity for social inclusion is predicated on their ability to be autonomous. In this form of citizenship madness and distress ‘are private particularities [that] leave skills and independence untouched, or are irrelevant to self-actualization’ (p. 99). The problem Pols

¹⁰ The report by the House of Commons Health Committee uses various terms from ‘black and minority ethnic’, ‘Mixed, Black and Black British groups’, ‘black communities’, ‘Black Caribbean, Black African and other Black groups’ and ‘migrant communities’ in their discussion of ethnicity and mental health law (2013, p. 33). They offer no details on how the data discussed was collected, including what each term or classification means. I have reproduced their terms here, acknowledging that it is unlikely that they are referring to Black as a political identification. This questions concerning terminology and statistical evidence requires further research and analysis that is beyond the scope of this article, which I intend to carry out.

(2006) finds with these enactments of citizenship is that '[i]t is unclear how the autonomous individuals can relate to one another, apart from not hindering each other' (p. 98); autonomy pits people's differences against one another. Even when increased sociality is the goal of self-actualisation it is secondary to strengthening the individual.

Patients must become citizens by conforming to, not by expanding what counts as a citizen, or what could count according to day-to-day collective negotiations. The implication of this is that autonomous choosing individual citizens are the same as each other. These forms of standardisation are marginalising and excluding. Furthermore, the respect for personal choice only stretches so far, and is classified according to presiding norms and values (which are white, masculinist, middle-class, etc.). Thus, the provision of choice creates the very possibility of deviance; there is a "right" choice and a "wrong" one. Autonomy is attributed to patients only when they continue to make the "right" choices in terms of self-care. The ideal of choice and its conflation with responsibility thus creates the very possibility for the removal of choice. Choice is contingent on conformity. As Diana Rose has observed, 'For all that [recovery] goals are meant to be "personal", certain goals are not permitted. You cannot decide to go to bed for a month' (2014, p. 217).

The Care Programme Approach

In the UK, the Care Programme Approach (CPA) is an example of these neoliberal enactments of choice and citizenship. The Care Programme Approach is a form of case management that was introduced into mental health services in 1991 to meet the challenges of co-ordinating multi-disciplinary care in the community. In *The Journey to Recovery* the CPA is described as 'central to Government policy' (Department of Health, 2001, p. 8) in ensuring continuity of care after a patient has been discharged. Although the document details that the CPA was 'not working' (ibid.), the new *National Standard Framework for Mental*

Health (NSFMH) (Department of Health, 1999) continued to include it as an important part of managing ‘people with severe mental illness’ (p. 41).¹¹ It is important to note that in the NSFMH people are sorted into different categories according to their relationship to mental health, from those with ‘common mental health problems’ (Department of Health, 1999, p. 28) to those with ‘severe mental illness’ (ibid., p. 41). As noted earlier, retaining the language of illness makes space for treatment without consent as for both the “good” of public health and the person who is “ill.”

The new NSFMH contained two standards (four and five) pertaining to those with “severe mental illness” that centre on planning for care in both a crisis and after hospitalisation, which are summarised in *The Journey to Recovery* in a section entitled ‘...if we use specialist mental health services’ (Department of Health, 2001, p. 15: emphasis added). The rhetorical use of an inclusive “we” draws on the discourse of inclusion in which some of “us” use specialist mental health services, and this is an unremarkable or normal part of community life:

We will then be involved in agreeing a care plan, which identifies *our* needs and how they can best be met, what *we* think *our* recovery goals should be, and what should happen if *we* experience a crisis. Care plans should recognise *our* broader social needs. (Department of Health, 2001, p. 15: emphasis added)

If “we” need specialist mental health intervention, then “we” will be placed on a CPA. This is euphemism for when people are detained under the Mental Health Act 2007; they become a case to be managed and will be engaged in that case management as subjects of choice. In the

¹¹ As I noted earlier, new National Standard Frameworks were introduced as part of the The NHS Plan (2000) providing standards against which local providers would be measured to ensure quality of care across the country.

age of care in the community, a marketised form of healthcare positions mental health service-users as choosing consumers of services that will meet their needs.

This enactment of patient as consumer elides the circumstances under which the patient came to be enacted as a subject of choice in the first place. Being “sectioned” under the Mental Health Act is precisely the removal of choice. Thus the CPA reinstates choice as an ideal, positioning patients as self-responsible subjects. This is done through limiting what the patient may choose from to a set of health and social care services. Concurrently, the patient is also enacted as a citizen and placed within a contractual agreement to manage their problems appropriately. The nature of appropriate self-management will be delineated by the expertise of the health and social care service providers they have chosen to rely on in crisis and in recovery. Any breach of this contract and their problems will again be managed for them through coercion. The CPA is thus a socio-material realisation of the discourse of self-responsibility that co-occurs with the ideal of choice in healthcare. Responsibility is defined in relation to irresponsibility, and this means madness and distress continue to be understood as a consequence of mis-management of the self.

The CPA is a “situation of choice” (Mol, 2008) in mental healthcare that encompasses a set of socio-material practices that enact mental health and mental health service-users in specific ways. Firstly, it enacts a person as having diverse “needs” that can be met by choosing from a selection of different mental health and social care services and products; the patient-as-consumer. Secondly, it enacts people with serious mental health problems as ones who should be working towards recovery and making plans in case of crisis; the patient-as-responsible-citizen.

The subject of a CPA must choose according to their needs, but as Pilgrim observes there are different enactments of need:

‘Patient-centeredness’, now at the top of the health policy agenda more widely, inherently focuses on voluntarism and mutually negotiated decision making between patients and professionals. Such an emphasis is on ‘expressed need’, whereas psychiatric decision making, backed up by legislative powers and expectations, requires an emphasis on ‘defined need’; it is an explicitly legitimised form of *parens patriae*. Logically and pragmatically, it is not, and cannot, be a negotiation between equal citizens. (2012, p. 73)

Furthermore, whilst *The Journey of Recovery* commits to the idea that health problems are linked to social inequality, in the context of a CPA ‘broader social needs’ (Department of Health, 2001, p. 15) may be ‘recognised’ (ibid.) but this does not impel further action. Because mental health continues to be articulated as “health” and a ‘clinical priority’ (Department of Health, 2001, p. 1) the focus continues to be on the autonomous subject with individual problems that are best met by psychiatric services and through self-responsibility.

Engagement and Compulsion

Recovery-as-policy focuses on medicine compliance (Moncrieff, 2003; Spandler & Calton, 2009). Indeed, standards four and five of the NSFMH include a commitment to the use of “anti-psychotic” medication as soon as possible with people experiencing psychotic episodes:

Prompt assessment is essential for young people with the first signs of a psychotic illness, where there is growing evidence that early assessment and treatment can reduce levels of morbidity . . . There is also evidence that delaying treatment with antipsychotic medication leads to poorer long term outcome for individuals with schizophrenic illness. Better public and professional understanding, together with

integrated mental health systems across primary and specialist services, will promote earlier intervention. (Department of Health, 1999, p. 44)¹²

This emphasis on “early intervention” is also referred to in *The Journey to Recovery*, in which early intervention teams for young people experiencing a first episode of psychosis will provide ‘help and advice on managing symptoms, and will base their care on the belief that *engagement, rather than compulsion*, is the key to success’ (Department of Health, 2001, p. 21: emphasis added). However, the terminology of “symptom management” remains, and the term “engagement” indicates a set of disciplinary techniques that are *a kind of compulsion*. This is a far cry from the self-definition fought for by psychiatric survivors and other mental health activists. Compulsion remains as an absent present, and if someone becomes “hard to engage” they will still be easy to coerce. For example, in the NSFMMH, it is stated that ‘[s]ome people with severe and enduring mental illness find it *difficult to engage* with and maintain contact with services, posing a risk to themselves or to others’ (Department of Health, 1999, p. 43: emphasis added). The risk these people pose is situated as lack of engagement; therefore there is no choice because if one chooses to disengage the medical professional response will be forced engagement with services. Spandler & Calton (2009) argue that what is implicit in the legal-medico alliance enacted in New Labour’s policies is ‘a conscious or tacit acceptance of a new body of psychiatric knowledge which defines the parameters of both ‘recovery’ and ‘inclusion’ (p. 252).

Designed to Fail

In her analysis of the *1981 Nationality Act*, Imogen Tyler has argued, ‘British citizenship has been *designed to fail* specific groups and populations’ (2010, p. 61: original emphasis). This failure is ‘foundational to British citizenship’ (2010, p. 62) as part of a wider

¹² There is notable longitudinal research that shows that early and continued use of neuroleptics actually decreases the possibility of recovery, e.g. Jablensky et al (1992) and Desisto et al. (1995).

redistribution of resources and rights away from the majority and into ‘the hands of the social and political elites’ (ibid.). The *1981 Nationality Act* redrew the lines as to who could claim British citizenship, removing the right from those living in former British colonies. Tyler details how this the Act racialized national belonging, and is therefore an example of what Foucault termed ‘state racism’ (ibid.), in which policy and legislation actively discriminate against people according to an essentialist concept of ‘race’. This politics of race is indelibly linked to class: ‘The 1981 Act produced ‘ethnic hierarchies’ in Britain, which, combined with existing class divisions, led to civil unrest. This in turn enabled minorities to be constituted as a ‘threat to the social body’ and targeted through policing and reform’ (Tyler, 2010, p. 64, citing Nelson, 2008).

Drawing upon this argument, I contend that the mental health legislation and policy analysed above can likewise be read as part of this racialized and classed design of British citizenship through the creation of failed subjects. Pilgrim and Tomasini (2012) have argued that failure in mental health legislation is characterised as ‘un-reason’ (p. 634). They contend that mental health law cannot be accurately be described as justice because it is discriminatory, highlighting inequalities in detention along race, class and gendered lines (Pilgrim & Tomasini, 2012). For example, data concerning those sectioned under the Mental Health Act (2007) demonstrates that those living in poverty, and especially Black men, are disproportionately sectioned in comparison to the rest of society (Pilgrim & Tomasini, 2012). In their 2013 post-legislative appraisal of Mental Health Act (2007), the House of Commons Health Committee found that since the act was passed there has been ‘a substantial increase in the detained patient population’, p. 3). Furthermore, ‘it is notable that the number of Black

and Black British patients subject to CTOs is even more disproportionate than the number detained in psychiatric hospitals' (ibid., p. 5).¹³

In mental health, specific people who do not meet the ideals of rationality, autonomy and individuality have been 'designed to fail' (Tyler, 2010, p. 61). These ideals are colonial, heteropatriarchal, and capitalist and inform the creation of a global detention complex that includes prisons, immigration detention centres, and institutions that detain disabled and psychiatrised people (Ben-Moshe, Chapman, and Carey, 2014; Lloyd et al., 2012). In the edited collection *Beyond Walls and Cages: Prisons, Borders, and Global Crisis*, Jenna Lloyd et al argue that 'the militarization of national boundaries and policing practices . . . prevents us from seeing the ways in which citizenship, incapacitation, and punishment work together, within and across national boundaries, to legally consign entire groups of people [disproportionately Black men and migrants] to precarious futures and premature deaths' (2012, p. 4).

Recovery-as-policy, with its commitment to the ideal of choice and citizenship, polices the crisis in psychiatric power brought about by rights-based movements by further criminalizing unreason and shoring up the idea that the "mentally ill" represent a threat to society. In doing so, the enactment of recovery-as-policy facilitates the removal of resources and rights for "mad" people, and as Costa (2009) rightly claims: 'we don't have recovery if we don't have rights'.

Conclusion

Tyler (2013) has argued that changes such as the ones I have described above are consequent forms of neoliberal policy-making which ostensibly attempt to deregulate stat

¹³ CTO means Community Treatment Order, meaning they are treated without consent (if necessary) outside of the hospital ward.

controls through the introduction of market mechanisms into welfare systems. In the case of the proposed changes to mental health policy analysed here, the idea of the ‘bad’ and outmoded welfare state (national mental health services) is located in that shameful history of neglect materialised in the total institution of the asylum. The neoliberal ideology posits that market capitalism will save us all from the abuses of state control through systems of devolved power, individual responsibility and choice. However, in actuality the ‘modes of surveillance and control hybridized and multiplied . . . on the one hand, neoliberal political discourses are state-phobic, and on the other hand neoliberalism demands continuous, repressive interventions by the state’ (Tyler, 2013, p. 6). This is exemplified in the paradox faced by people experiencing madness or distress whom are promised individual freedoms within a system that increasingly threatens those freedoms through the unrealisable ideals of free and rational choice.

In this paper, I have offered an analysis of recovery-as-policy beginning with New Labour’s reforms of the NHS, which in the area of mental health was referred to as *The Journey to Recovery*. I have shown that the government told a particular history of mental healthcare in UK that was one of neglect, and yet made no mention of psychiatric practices that are harmful at best and fatal at worst. I argued that this is because the new policy and NSFMH laid the ground for new mental health legislation that would be increasingly repressive. Overall, this tension between patient-centred policy focussed on the ideal of choice on the one hand and the legal right to detain and treat patients without their consent on the other enacts those who identify as mad within a paradox. Highlighting the inequalities in distribution of detention and coercion, I have argued that recovery-as-policy is a form of neoliberal state-making that is discriminatory and unjust.

In the years following the uptake of recovery in the UK mental health practice, we receive repeated reports that the mental health system continues to be in “crisis”. I caution against this discourse as one that is used to reassert the chokehold biomedical psychiatric practices and state legislation have in determining how mental health service-users should live their lives. This story silences and marginalizes alternatives (Ben-Moshe, 2014).

If detention and exclusion are constitute elements of the global neoliberal complex, in what ways might activists forge links between movements such as No Borders and prison abolition? Crucial work in developing these connections around madness and mass incarceration has begun with the publication of *Disability Incarcerated* (2014), and emerging scholarship which seeks to highlight the connections between multiple forms of disenfranchisement, dispossession and social injustice (see for example, Tyler, 2013; Lloyd et al., 2012; McWade, Milton and Beresford, 2015). Could we, like Angela Davis and Gina Dent (2001) do for prisons, conceptualise psychiatric services as a state border, through which certain bodies are produced as deviant in order to capitalise upon those bodies as sites for accumulation?

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