The Re-covering Self: a critique of the recovery-based approach in India's mental health care

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This paper critiques recent initiatives for deploying the Recovery Model in the Indian sub-continent. It traces the history and growth of the model, and questions its applicability for mental health care in the Indian sub-continent. The authors argue that mental health professionals in this region are at the crossroads of a familiar past: either to uncritically import and apply a Euro-American 'recovery' model or re-configure its fundamental premise such that it is embraced by the majority Indian population. The paper proposes a fundamental re-thinking of existing culturally incongruent 'Recovery Models' before application in India's public mental health and clinic settings. More crucially, policy makers, clinicians and researchers need to reconsider the local validity of what constitutes 'recovery' for the very people who place their trust in State mental health services. This critical reappraisal, together with essential culturally-sensitive research, is germane to prevent yet again the deployment of culture-blind programmes and practices. Addressing these uncontested issues has profound implications for public mental health in the Global South.

Keywords: recovery; clinically applied anthropology; India; local mental health; global mental health; cultural psychiatry

Introduction

'Thanks to the advances of psychopharmacology, clinical psychology, neuro-psychology, modern behavior therapies, we are able to bring superior changes in our patients' recovery from their sufferings. This psycho-social understanding is paving way to the newer horizons in quality of life of our patients and their families' (Welcome address, ANCIPS 2015).

This professional assertion at the 67th Annual National Conference of the Indian Psychiatric Society (ANCIPS, 2015) indicates significant attention dedicated to 'Recovery and Social Inclusion'. It highlights India's recent drive to adopt terms and models that have dominated policy planning and service provision of several high-income countries including the US (US Department of Health and Human Services, 2003), the UK (Boardman and Friedli, 2012) and

Australia (Australian Health Ministers, 2003).

In the past year, legislative and policy trends in India have mirrored this paradigm shift in care provision and moved towards promoting recovery-based practices (MOHFW, 2013; MOHFW, 2014). The Indian Mental Health Care Bill 2013 (currently pending in the Rajya Sabha, Upper House, Parliament of India) outlines one of its primary objectives for mental health care in India:

> Persons with mental illness should be treated like other persons with health problems and the environment around them should be made conducive to facilitate recovery, rehabilitation and full participation in society (MOHFW, 2013: 56)

Similarly, the recently released progressive Indian National Mental Health Policy calls for an integrated, participatory and rights-based approach to mental health. The Policy defines 'recovery' as 'a process of change through which individuals improve their health and well-being, live a self-directed life and strive to reach their fullest potential' (MOHFW, 2014:i). It emphasizes the need for inter-sectoral collaboration, optimisation of human resources and universal access to mental health care services embedded within a value framework.

The modern notion of 'Recovery' has moved away from its original definition as an outcome implying the absence of symptoms in a patient (clinical recovery) towards that of a process or 'journey of change' (personal recovery). This implies that patients[1] learn to re-engage with local ecosystems (Onken et al., 2007). It simultaneously encompasses crucial personal and social dimensions. On a personal dimension, recovery stresses the importance of patients' empowerment and responsibility towards 'regaining control over their lives' through self-determination and self-direction. Along a social dimension, recovery acknowledges the crucial need for the 'reintroduction of the individual into a socially accepting and acceptable environment' (Secker et al., 2002: 410). Notions of normative and inclusive citizenship are thus at the heart of the process of recovery (Vandekinderen et al., 2012). Social inclusion has therefore been advocated as essential to make recovery possible by creating enabling social and cultural environments (McCranie, 2010). Indeed, recovery is both predicated and contingent upon local political economies (Warner, 2004).

Over the past decade, service providers across the globe have taken several steps towards ensuring a paradigm shift in the delivery of mental health services from a traditional clinical model to a recovery-oriented model. This includes the cultural as well as intellectual transition of viewing patients as experts in their own care. Therefore, it emphasizes the value of patients' individual narratives within local social and cultural contexts so as to allow for personal growth and self-management (Slade, 2009). Mental health systems adopting the recovery paradigm are also designed to be participative and centered on individual needs. Care that was once confined within a medical or psychiatric model has now 'progressed' to

offering comprehensive and appropriate solutions that view patients in relation to their cultural, social, economic and ecological environments (SLAM and SWLSTG, 2010).

The growing importance of this concept on the international mental health policy landscape has, however, failed to consider the substantial body of evidence highlighting the concept's lack of clarity (Hopper, 2007; Adeponie, Whitley and Kirmayer 2012) and the absence of evidence surrounding its cross-cultural applicability (O'Hagan, 2004). In view of such critiques, the recent endorsement of this concept in Indian mental health policies and professional rhetoric raise profound concerns. In this paper, we argue that the benefits and limitations in implementing such a model in India's mental health program warrant serious reconsideration. Indeed, whilst the transition to a recovery-oriented model of care might be viewed as a welcome change in India, reflection on its cultural origin and local relevance, including its functional and structural limitations, is vital for shaping translation of policy to service delivery.

This paper outlines the conceptual, clinical, research and policy challenges for applicability of the 'Recovery Model' in the Global South with a specific focus on the Indian sub-continent. We aim to demonstrate how existing western notions of recovery have yet to demonstrate their cross-cultural validity for the majority world. The paper expands upon this argument by deconstructing a brief cultural history of existing 'recovery models', examination of published research and cultural ethical implications for the Global South. We argue for a grounded and culturally valid approach to what constitutes 'recovery' outside of Euro-American societies. The paper concludes that, in order to ensure success of 'mental disability' concepts and models for the Global South, it is necessary for these to be locally rooted and to incorporate nomenclatures, experiences and aspirations of people in pursuit of solutions to their struggle and survival.

Cultural history of Recovery

An analysis of the cultural-historical construction of the concept, policy and practices of the recovery model is critical for identifying challenges in its application within the Indian sub-continent.

Two parallel movements, the Independent Living and Civil Rights Movement[2] (ILCRM) (Deegan, 1993 cited in Davidson et al., 2006), and the World Health Organization's International Pilot for the Study of Schizophrenia[3] (IPSS) (WHO, 1973) have shaped the historical development of the concept of 'Recovery'. These distinct frameworks could also be viewed in a sociological sense as 'mythic templates'. Each template has been shaped by a prototypal myth that has structured its course and, ironically, its outcome. Over the past four decades, these templates have seemingly merged and generated little consensus on what this

means in relation to mental illness in Euro-American societies.

The first, ILCRM, was a civil rights movement rooted in physical disability and Alcoholic Anonymous programs. The second, IPSS, was a landmark study on outcome and prognosis for Schizophrenia across cultures. The publication of a major US policy titled 'President's New Freedom Commission on Mental Health' in 2003, culminated into a merger of critical themes that arose from these two historical parallel movements. Consequently, published literature reflects confusion in terminologies that have mushroomed into numerous semantic categories with their own histories and cultural origins. These include a plethora of terms: recovery, recovery model, recovery-oriented practices, recovery from and recovery in, symptomatic recovery, external versus internal recovery, partial recovery, and social recovery (Jacobsen and Greenley, 2001; Davidson and Roe, 2007; McCranie, 2010).

This conceptual and semantic confusion has been further exacerbated by contradictory interpretations amongst various stakeholders: patients demanding autonomy and human rights, health providers focusing on models and methods, and policy makers emphasizing control, efficiency and reduction of economic burden (Bonney and Stickley, 2008). In addition, the concept of recovery has been used to refer to 'an approach, a model, philosophy, a paradigm, a movement, a vision and, skeptically, a myth' (Roberts and Wolfson, 2004 cited in Adeponie, Whitley and Kirmayer, 2012: 38).

Despite these unresolved contradictions and varying interpretations, a global 'political effort' to address patients' concerns over human rights has led to the operationalization of 'recovery' within official policy guidelines and the publication of practical manuals (Australian Health Ministers, 2003; Davidson et al., 2008; HM Government, 2009; Copeland et al., 2014). In short, 'recovery' in Euro-American mental health care is now a politically correct prefix for any mental health intervention, despite a continuing lack of conceptual clarity (Bonnet and Stickley, 2008; Onken et al., 2007).

Sociologists have argued that charismatic movements like the ILCRM and Alcoholic Anonymous movements emphasising 'agency' and 'transformation', respectively, led to the adulteration of 'true' believers by careerists and those who 'just need a job', which 'dilutes the intensity of commitment' (James and Field, 1992:1372). This Weberian analysis suggests that when charismatic movements are exposed to everyday demands, they 'inevitably become confronted with the need to create an administrative machine, acquisition of funds, and the problem of succession – and so the process of routinization begins' (ibid, 1992: 1365).

Anthropologists, on the other hand, have critiqued the promise of 'recovery' as a failure to acknowledge the role of political economies- the degree to which society can accommodate the return of a patient into the community and facilitate recovery (Warner, 1994 cited in Hopper, 2007). Thus 'critical variables such as race, gender, and class tend to fade away into

unexamined background realities, underscoring the defining centrality of psychiatric disabilities in these lives' (Hopper, 2007: 871). Indeed, these assertions have also been echoed in several other publications (see Jones et al., 2007; Ramon et al., 2007; Slade et al., 2012; Reupert et al., 2015).

To summarise, Hopper (2007: 871) names the elephant in the room in his succinct analysis:

> ...vital contextual features – the enabling resources, rules and connections that make prize prospect like a decent job feasible – are either disregarded or casually remarked, as though their provision were unproblematic or of lesser concern to individual reclamation project... community living is taken as given... to speak of a model of recovery is thus misleading. Movements are not peer reviewed.

Instead, Hopper (2007) argues for providing an alternative framework drawn on Amartya Sen's 'capabilities' approach. However, this approach has yet to be operationalised chiefly due to its vagueness in making explicit specific details that constrain its practical application. As a result 'it remains unpersuasive to those who look for clarity, let alone precision' (Gasper, 2007: 337).

Significantly, research led by those who have suffered from 'mental illnesses' have argued that recovery lies in the social context within which this process occurs (May, 2000). A recent systematic review for personal recovery in mental health within Europe and North America, focusing on first person accounts of recovery across cultural groups, concluded that there were significant variations between white Euro-American and Black ethnic minority groups in two domains: culturally specific facilitating factors; and collectivist notions of recovery (Leamy et al., 2011). These findings underscore the essential role of culture as a crucial determinant in recovery (Carpenter-Song et al., 2010; Myers, 2010; Adeponle, Whitley and Kirmayer, 2012; Kartalova-O'Doherty et al., 2012; Todd et al., 2012; Tse and Ng, 2014). Yet, current literature on recovery is largely predicated on Western Euro-American populations. In brief, recovery research continues to pursue a 'monocultural' approach (O'Hagan, 2004).

Considering the above criticisms, it may not be surprising that the uptake and success of recovery-based services in the Global North have so far been moderate. The recent conceptualization of recovery as 'a site of socio-political struggle over what lives are deemed livable in the context of global neo-liberalism' (McWade, 2015: 244) further shows how neoliberal values and pressures to deliver tangible service outcomes have negatively impacted the temporal nature of such a struggle. By compromising the co-constitutive process of temporalities and subjectivities at the center of one's recovery project, such imperatives have highlighted 'the potentials for harm in neo-liberal practices of temporal governance' (ibid, 2015: 257) on the process of recovery. As such, it raises important

questions on the model's ability to challenge the 'chronicity' paradigm of the dominant model of biomedical psychiatry within this political landscape (Morrow, 2013).

The implementation of recovery-based approaches in a neoliberal policy context has also been criticised in light of the ideological relation tying bio-psychiatry and neoliberalism in promoting individualistic understandings of complex social problems and market solutions (Morrow, 2013). Rather than challenging the predominant biomedical model of psychiatry as first intended, the uncritical application of recovery-based practices in this political scenario has often resulted in a systematic omission of the importance of social and structural barriers in one's experience and understanding of mental illness. The latter has been loudly echoed by patients who have argued that political interests and the application of market-driven principles to the delivery of mental health services have resulted in the disappearance of the social justice principles behind the recovery approach (Howells and Voronka, 2012; McWade, 2015).

The nature of these arguments and debates assume critical importance in view of current transnational movements of knowledge about mental health policies (White, Jain and Giurgi-Oncu, 2014). In recent years, Global Mental Health (GMH), a discipline and a movement (referred to as mGMH or Movement for Global Mental Health) driven by a coalition of academics, mental health professionals and patients, has sought to improve access to mental health care in low and middle income countries to reduce inequalities in provision of care. The GMH movement has played an increasingly significant role in North-South knowledge transfer in mental health, primarily through efforts to re-shape mental health policy and service delivery through 'evidence-based' interventions (Lancet Global Mental Health Group, 2007; Patel et al., 2011). However, critics have questioned the cross-cultural applicability of the GMH 'evidence' base, much of which is based on research conducted in Euro-American contexts. They argue that such interventions promote medicalization of distress and forsake local particularities (Das and Rao, 2012; Summerfield, 2012). Recently, a publication by core members of the mGMH whilst discussing the future of GMH (Global Mental Health) states that *'we must insist on seeking recovery for all who have mental disorders…'* (Patel et al., 2011:90). However, the publication does not detail any particular conceptualization of recovery. Furthermore, Mills (2014) points out how the language of global mental health, including the focus on chronicity and the disabling nature of severe mental illness, is in direct contrast with the emphasis on hope, empowerment, and the social components that underlie high-income countries' approaches towards recovery. Considering the increasing focus of GMH in attempting to link mental health with development (Plagerson, 2015), it is plausible that such movements may contribute to the globalization of a Western 'recovery' model. These critiques invite a serious re-think on the appropriateness of this concept of 'recovery' for mental healthcare in the Indian sub-continent.

Challenges for implementation in the Indian context

Considering the Euro-American cultural history of this concept and its current lack of clear theoretical and operational definition, a blanket implementation of Western recovery-based practices in India faces major challenges. The absence of a cultural redefinition for recovery in the Indian context may well result in the loss of crucial relevant practices within India's 'formal' and 'informal' mental health care. In the current context of an under-resourced mental health care system, in which both psychiatric hospitals and personnel are scarce, the patient's family is often assumed as the cornerstone of her care (Shankar and Menon, 1991; Addhlakha, 2008; Marrow, 2008) and as key informants for mental health professionals (Nunley, 1998). This is an important factor in promoting mental health recovery, and requires a nuanced examination in light of the rapidly changing family structure in contemporary India (Kapur, 1992; Desai, 2010). However, the emphasis that recovery places on the patient as an individual expert of their own care may result in the exclusion of patients' families from this process. Furthermore, the supposedly co-productive therapeutic relationship (Slay and Stephens, 2013) underlying recovery-based practices, resulting from the shift of expertise from doctors to patients, may fail to meet the expectation of many Indian patients and their families who often expect their doctor to assume an authoritative, benevolent and prescriptive role (Neki, 1973; Jadhav, 2011).

Additionally, several other cultural considerations are critical. The nexus between self-actualisation and self-individualisation renders the notion of recovery attractive to members of societies in which such concepts have become ideals for which to strive (Roland, 1989). In fact, such approaches may well be irrelevant to the local cosmologies of the majority rural Indian population for whom self-actualisation remains intrinsically bound to their family and community (Laungani, 1992; Kakar, 2007). Critical Disability Studies literature addresses the relationship between biological impairments, personhood and differences between how persons are culturally defined (Whyte and Ingstad, 1995). For example, Whyte and Ingstad (1995) discuss the idea that Western conceptions of disability emphasizing autonomy and independence may be linked to a society predominantly emphasizing ego-centric notions of personhood. In contrast, societies where the dominant mode of personhood is socio-centric, may value reliance on one another, and this may be viewed through lenses of love and mutuality. These arguments have direct relevance to recovery in relation to 'psycho-social disability', for example, how do ideas about personhood shape a particular community's conception of what constitutes 'recovery'? Therefore, it is evident that mental health disciplines in India ought to take into account the intricacies of local and heterogeneous Indian contexts of recovery. The recovery model, by focusing on the individual rather than the family and community, supports and propagates a neoliberal model of development (Callero, 2008; Inglehart and Baker, 2000).

In light of these arguments, the interplay between the concept of 'recovery' and the

institutional apparatus supporting its deployment should also be closely examined. At a macro-systemic level, the current lack of coordination between India's welfare state and official healthcare raises doubt over the actualisation of the fundamental values at the core of recovery. Indeed, the 'holistic' approach underlying the concept of recovery requires a great degree of coordination and integrated planning between the nodal ministries responsible for the various mental health professional bodies involved in the delivery of such an approach. The current structure underlying health and social policy implementation in India hinders such synchronisation (Peters, Rao and Fryatt, 2003; Mooij, 2007).

The implementation of recovery-based services in India also ought to consider its impact on services to demonstrate outcomes. Indeed, the increasing burden of non-communicable diseases in India, including mental health, demands that the Indian psychiatric profession urgently demonstrates its ability to improve the lives of the patients it treats. This will ensure mental health to be more prominent on the public health agenda and secure the funding it much requires (Prince et al., 2007). However, due to the current lack of agreement regarding its definition and its inherently individual nature, 'Recovery' as a service outcome is notoriously hard to measure though quantitative variables (Williams et al., 2012). Yet, tools to measure various aspects of recovery have indeed been developed and deployed in service outcome research. The Questionnaire about the Process of Recovery (QPR) (Neil et al., 2009) and the INSPIRE scale have been used to capture personal experiences of recovery and patients' views (Williams et al., 2012). Similarly, the Wellness Recovery Action Plan[4] (WRAP) (Fukui et al., 2011; Cook et al., 2012) and the Recovery Outcome Star[5] (Killaspy et al., 2012) have been demonstrated to be useful in identifying factors that may hinder or promote recovery, and in supporting co-productive ways of mapping the changing characteristics of services users' journeys of recovery (Shepherd et al., 2014). Nevertheless, such tools have yet to demonstrate their efficacy in the Indian context. In the absence of evidence demonstrating the cross-cultural validity of deploying such instruments, these research methods are not just about culturally insensitive approaches or 'category fallacies' (Kleinman 1991). In fact, they are potential mechanisms that may generate erroneous categories through the process of 'cultural iatrogenesis'[6] (Jadhav, 2007).

In practice, the absence of a strong formal social care system designed to support psychiatric patients in India also represent a crucial challenge – existing social care networks primarily reside in the non-formal sector: within families, in the community, and in wider cultural spaces (Pakaslahti, 1998; Halliburton, 2009) Additionally, specific national schemes aiming to provide financial and housing support, which may facilitate a patient's journey to recovery, are strikingly absent in India, with the exception of a few successful initiatives piloted in the NGO sector (Davar, 2012a). The lack of services for people suffering from poor mental health to impart skills required to return to gainful employment, such as the now popular 'recovery colleges' in the UK (Perkins et al., 2012), further reduces their prospect for social inclusion. A successful recovery also depends on the possibility for patients to receive

ongoing and timely professional care. However, India's shortage of trained mental health professionals makes such a requirement nearly impossible (Thirunavukasaru and Thirunavukasaru, 2010). Additionally, the crucial role of social workers in promoting recovery, and advocating for and providing ongoing support to persons suffering from poor mental health in the community, is well established (Tew et al., 2011; Webber and Joubert, 2015). Yet the paucity of psychiatric social workers in India, in addition to their perceived lower status amongst mental health professionals (and within wider Indian society), is a disquieting phenomenon that compromises any recovery model to be put in practice (Kakuma et al., 2011; Orr and Jain, 2015). Finally, insufficient human resources for delivering mental health services often translate into poor multidisciplinary care, thus directly raising questions about the feasibility of the holistic approach underlying recovery-based practice.

On the other hand, the role and status of folk and traditional healing practices and sites in a recovery-oriented mental health system in India has yet to be considered. Such practices have an ambiguous status in Indian society – they, arguably, play a central role in promoting well-being, healing and promoting social welfare schemes for large populations (Raguram et al., 2002), whilst also being viewed by the state and popular media as sources of abuse, coercion, and irrationality (Quack, 2012). More recently, traditional healing sites have been increasingly regulated by the State (Davar, 2012b). The global mental health movement has, through its focus on 'evidence-based' practice, taken a stand that precludes meaningful cooperation with those outside the biomedical domain. Significantly, recent experiments to integrate psychiatry with traditional healing practices in India have been primarily driven by the discipline of psychiatry on its own terms, rather than through genuine collaborative efforts (Khare, 1996; Basu, 2009, 2014). In fact, ambitious efforts in the 1960-70s aimed at integrating traditional and biomedical models failed to sustain this romanticism (Franklin et al., 1996; Kigozi and Kinyanda 2006; Lambo, 1960). This raises questions as to whether a 'recovery movement' that is locally rooted in the Indian socio-cultural context can either ignore or collaborate with popular 'traditional' practices that potentially contribute to the 'recovery' of large numbers of people suffering from poor mental health.

Introducing recovery in the Indian context

The increasing burden of structural violence (poverty, homelessness, stark and blatant inequities, caste, gender and religious discrimination), substance abuse, conflict, familial discord, and the transitional nature of the socio-cultural fabric of Indian society, are part of the social factors that shape mental distress in India (Kuruvilla and Jacob, 2007; Jadhav and Barua, 2012). Together, they indicate the urgent need for transition to a robust mental health system that is wellness-driven, holistic, responsive, and inclusive. Indeed, the social and cultural dimensions shaping suffering of most psychiatric patients is seldom acknowledged in the current Indian mental health landscape. This landscape is largely dominated by

psychiatrists relying on an 'illness'-oriented model of care delivered chiefly through pharmacological interventions (Nunley, 1996; Jain and Jadhav, 2009). A shift to a culturally-sensitive recovery-based practice defined and rooted in local realities could thus potentially contribute to validating and legitimizing the role of socio-cultural factors in the management and rehabilitation of people suffering from poor mental health. This is glaringly absent despite numerous mental health policies advocating for a biopsychosocial approach to mental health. Indeed, such an approach is seldom operationalized in the clinic, which continues to privilege bio-medical interventions (Jain and Jadhav, 2008).

By directly emphasizing the inherently socio-cultural nature of mental health, a transition to culturally relevant recovery-based practices would incentivise mental health professionals to seek alternatives to exclusively pharmacological interventions. In this context, 'social prescribing'[7] may prove to be an effective strategy to aid recovery, alleviate distress and promote social inclusion by allowing individuals access to social entitlements (ration cards, identity proof, housing benefits, educational allowances, old age pensions, livelihood schemes, etc.), participation in community activities and engagement in creative pursuits (South et al., 2008; Thomson et al., 2015). This mitigates several socio-economic phenomena that otherwise play an adverse effect on achieving recovery and wellness outcomes. In India and many other lower-middle income countries (LMIC), individuals often grapple with the burden of poor mental health and poverty (Trani et al., 2015). Thus it is imperative that strong social care systems are put in place and existing informal systems supported to complement pharmacological interventions in order to minimize the chances of affected peoples' further descent into poverty. Despite the complexities inherent in developing such systems, and the time scale required to do so, these developments should be considered by both state health and social services in India as crucial for medium to long term objectives.

This potential change in the 'culture of care' should occur simultaneously with the emergence of recovery-focused services in India. As such, it could also directly impact patients by heightening their status and rights within the mental health system. An over-emphasis on doctors' expertise and a singular emphasis on pharmacological treatment result in patients' deep narratives of suffering being overlooked within current models of care (Jadhav and Barua, 2012). This limits the impetus for stakeholders of the current mental health system to develop and introduce other therapeutic modalities. Whereas this dynamic has partly been shaped by cultural expectations regarding the role of both doctors and patients, it has also resulted in poor patient representation, fewer peer support initiatives and, in severe instances, human right violations (Human Rights Watch, 2014). A renewed focus on patients' expertise would remedy some of these issues and shape the development of future 'bottom-up' Indian mental health services. Similarly, increased patient involvement in the healthcare system could transform the current mental health workforce to include a larger proportion of people with lived experiences in a counseling or supporting role so as to promote recovery among other patients (Heartsounds, 2015).

Recovery in India: at a crossroad

The use of a 'recovery' concept for mental distress in India glosses over multiple philosophies and models. It uses ideas and research findings from the Global North and applies them to the Global South, a process that diminishes the centrality of the local social context. It presumes an egalitarian doctor-patient relationship and, in the process, marginalises local healing systems that do not fit within the discourse on recovery. It also distorts policy planning by focusing on individual needs rather than community concerns.

Despite these challenges, the authors argue that currently advocated implementation of recovery-based practices has resulted in an important crossroad for India's mental health professionals. On one hand, by failing to reappraise such concepts in the context of the rapidly evolving and transitional nature of the socio-cultural fabric of Indian society, the nation's mental health professionals might once again be held accountable for the uncritical import of Western mental health concepts. As Grech (2011:97) states in a discussion on disability and development:

> The need to underline the primacy of the local remains a critical issue, because in the absence of this, the quest to universalise and generalise from North to South will remain a flawed, reductionist and ethnocentric enterprise.

In fact, this has already resulted in a growing cultural distance between Indian mental health professionals and their patients, as well as poor uptake of rural mental health services (Jain and Jadhav, 2009). On the other hand, the development of culturally appropriate mental health concepts of recovery may provide a crucial opportunity for the profession to recover its 'self' and overcome the 'post-colonial paralysis' (Nandy, 1983; Jadhav et al., 1999) responsible for the predominant flow of psychiatric knowledge from Euro-American nations to the Indian sub-continent. Such developments may in turn offer an opportunity for mental health professionals in India to renew their social contract with local communities.

At the crux of this renewed contract, mental health professionals in the Indian sub-continent may need to revisit their role in promoting mental well-being rather than focusing on the 'cure' of mental illnesses (White, 2010). By explicitly stating that mental health is not merely about treating 'illness' and 'disorders' but also about exploring positive dimensions, Indian mental health professionals might be better positioned to define and understand what it means to be 'healthy' in 21st century India. With this new aspiration in mind, it will rapidly become essential for health professionals to advocate for a national scheme to tackle the social determinants of health such as poverty, lack of access to sanitation, caste and gender discrimination, homelessness, disasters and displacement, and local ecologies of suffering arising from conflicts over natural resource ownership (Jadhav, 2004, 2012; Jadhav et al., 2015). In order to do so, a reexamination and reengagement with the new framework of

'clinically applied anthropology' by mental health professionals and social scientists in India would be productive (Jadhav, 2001; Oliveira, 2010; Derges et al., 2012). Arguably, this may result in initiatives focusing on prevention, contribute to highlighting mental health suffering on a par with physical health, foster better integration with social welfare schemes (Doherty and Gaughran, 2014), and avert chronicity and social defeat (Luhrmann, 2007). These crucial determinants of recovery are in keeping with recommendations by international health organizations that question the basis of 'treating people and sending them back to the very conditions that made them sick' (Marmot, 2015: 8).

Before jumping on to the bandwagon of 'Recovery models', primary and secondary research is urgently needed to identify Indian vernacular concepts of 'recovery', their cognate and embodied equivalents. This can be interpreted only in relation to any society's core notions of the self, moral agency and intentionality, together with its lexicon of affect, categorical logic and contingent recourse to therapy (Jadhav and Littlewood, 1994). Unless this complex mesh is unpacked and understood, the uncritical import of 'recovery' as a meaningful locally valid concept for the Indian population is poised to generate yet another 'category fallacy' (Kleinman,1991). If unattended, they raise serious social and ethical concerns that bear upon mental disability in the Indian sub-continent. These matters have profound implications for the lives of people suffering with mental disability, on the discipline of public mental health, and their services in the Global South.

Notes

[1]The recent increase in popularity of the recovery movement has been accompanied by multiple semantic reconfigurations. The word 'patient' has thus been replaced by the term 'service user' and more recently by 'client' to underline a conceptual shift in expertise from doctor to patient, and denote people's right to choose and purchase various interventions/services contributing to their well-being. In this article, the authors have chosen to use the word 'patient' as it best represents the current sociological role adopted by many Indians suffering from poor mental health, often in the absence of formal mental health services. Despite doing so, the authors also wish to recognise and promote the expertise of *both* parties involved in the therapeutic encounter.

[2] The Independent Living and Civil Right Movement (ILCRM) originally stems from the American civil rights and disability rights movements of the late 1960s, and is seen by many as a philosophy and a way of looking at disability and society. Notably, it opposes the medical view of disability as a form of defect or lack, and promotes the idea of equal opportunities for people with disability by acknowledging their expertise on their own needs. It sees people with disability first and foremost as active and independent citizens of democratic societies rather than dependent consumers of social and health care services. Accordingly, it encourages people with disability to engage in self-advocacy, and organise

themselves for political power to take individual and collective initiatives to promote, design and implement better interventions and solutions for their well-being.

[3] The International Pilot Study of Schizophrenia (IPSS) was the first large-scale comparative cross-cultural research on the presentation of schizophrenia (Sartorius et al., 1972; Jablensky et al., 1992). It involved 9 centres across 4 continents with 1202 patients between the age of 15 and 44. The conclusions reached by the WHO following the study were: a) Schizophrenia is a universal disorder found across the globe b) despite no symptoms being invariably present in every patient and every setting, the clinical picture associated with the diagnosis of schizophrenia was remarkably similar at the level of symptom profile; c) despite this universality, there is great variation in the course and outcome of the illness; d) in follow-up studies, the prognosis for the illness was found to be better for patients in developing countries (Girolamo, 1996). The conclusion of these studies have been criticised by multiple authors (see for example Waxler (1979) and Williams (2003).

[4] The Wellness Recovery Action Plan (WRAP) is a support tool for patients composed of various modules such as the 'Wellness Toolbox', 'Planning and scheduling', 'triggers and warning signs and 'post-crisis planning' sections. As a whole, it aims to identify and schedule activities beneficial to patients, while helping them understand the triggers and early warning signs which may indicate poorer well-being or a risk of relapse. It also compiles a plan for the patient's carer detailing how s/he wishes to be cared for in times when decision making abilities might be impacted by the patient's illness.

[5] The Recovery Outcome Star is often seen as an intervention with primary function to 'mobilise the agency of the service user and the worker towards achieving recovery outcome for the service user' (Outcome Star, 2013). The patients' progress is mapped on a 'Journey of change' (stuck, accepting help, believing, learning, self-reliance) alongside ten 'Outcome Areas' including: managing mental health, work, social networks, identity and self-esteem, relationships, and addictive behaviours. For more information about the psychometric properties of the Recovery Outcome Star, see Dickens et al. (2012) and Killaspy et al. (2012).

[6] Abstracting local explanations of suffering to the level of a psychopathology constitutes 'cultural iatrogenesis'. See Jadhav (2007, 2009) for examples of western derived research instruments that can generate culturally invalid concepts. This paper argues that such instruments are potential 'weapons of violence' (Farmer, 2004).

[7] Social prescribing is an innovative approach, which aims to promote the use of the voluntary sector within primary healthcare. Social prescribing involves the creation of referral pathways that allow primary health care patients with non-clinical needs to be directed to local voluntary services and community groups (South et al., 2008). More recently, social prescribing has been defined 'a mechanism for linking patients with non-medical sources of support within the community' (Thomson et al., 2015).

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