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"Recovery" in mental health services, now and then: A poststructuralist examination of the despotic State machine's effects

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Abstract

Recovery is a model of care in (forensic) mental health settings across Western nations that aims to move past the paternalistic and punitive models of institutional care of the 20th century and toward more patient-centered approaches. But as we argue in this paper, the recovery-oriented services that evolved out of the early stages of this liberating movement signaled a shift in nursing practices that cannot be viewed only as improvements. In effect, as "recovery" nursing practices became more established, more codified, and more institutional(ized), a stasis developed. Recovery had been reterritorialized. The purpose of this paper is to examine some of the threads of recovery, from its early days of antipsychiatry activism to its codification into mental health—including forensic mental health—institutions through the lens of poststructuralist philosophers Gilles Deleuze and Felix Guattari. We believe that Deleuze and Guattari's scholarship provides the necessary, albeit uncomfortable, framework for this critical examination. From a conceptualization of recovery as an *assemblage*, we critically examine how we can go about creating something new, caught in a tension between stasis and change.

KEYWORDS

assemblage, Deleuze and Guattari, mental health nursing, poststructuralism, recovery

1 | INTRODUCTION

Recovery represents a set of policies and a model of care in mental health nursing settings across Western nations that aims to move past the paternalistic and punitive models of institutional care of the 20th century and toward more patient-centered approaches. The term is broad in its range of definitions and manifestations. It represents contemporary nursing care orientations, practices, and institutional policies. For about three decades, it has enjoyed widespread implementation as policy in mental health nursing settings in the United States (Jacobson & Curtis, 2000), Canada (Piat & Sabetti, 2012), the United Kingdom (McWade, 2016), Australia (Ramon et al., 2007), and beyond, and has more recently been implemented in secure forensic mental health settings in these jurisdictions. It is challenging to identify a single definition of recovery given its widespread implementation (Pilgrim & McCranie, 2013). According to McWade (2016), "the history of recovery has multiple threads and is still in process" (p. 62).

Current manifestations of recovery in mental health settings differ significantly from recovery's origins. What started as a

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perspective and collection of practices, and a patient/survivor-led response to deinstitutionalization, rooted in the social justice movements of the 1960s and 1970s, eventually merged with the psychiatric rehabilitation movement of the 1980s, morphing into more institutionally based recovery-oriented services, famously defined by Anthony (1993). By the 21st century, recovery had become widespread official policy for institutional mental health services across the Western nations, including in secure forensic mental health settings (Drennan & Alred, 2012). And while recovery advocates report that the model offers patient-led care for those living with mental health issues, based on hope and patient autonomy, critics have argued that its current manifestations as institutional policy have all but abandoned recovery's radical and antipsychiatry origins. Instead, many argue, recovery has been co-opted by mental health service providers, including nurses, and has become a coercive vehicle for neoliberal-oriented healthcare services (Howell & Voronka, 2012; McWade, 2016). This history of recovery cannot be viewed as homogeneous or linear. Its origins and implementations have varied over time and place. As McWade (2016) stated, “it cannot be understood to belong to any particular moment or movement in mental health” (p. 62).

The purpose of this paper is to critically examine some of the threads of recovery, from its early days of antipsychiatry activism to its codification into mental health—including forensic mental health—service institutions in Western nations through the lens of French philosophers Gilles Deleuze and Felix Guattari. We argue that what started as a radical, user-led perspective and collection of practices has shifted significantly to a practitioner-led set of policies and practices that no longer resemble recovery's origins, with recovery in secure forensic settings representing the most dramatic shift. In particular, Deleuze and Guattari's (1987) seminal work, *A Thousand Plateaus: Capitalism and Schizophrenia*, provides the framework for this examination. From a conceptualization of recovery as an *assemblage*, we will critically examine how we can go about creating something new, caught in a tension between stasis and change. The continuum between stasis and change offers a framework for Deleuze and Guattari's (1987) concepts of royal and nomad science, the despotic State machine (dSm) and the war machine (Wm), striated and smooth space, and reterritorialization and deterritorialization, all of which will be employed in this critical analysis of recovery. Such an analysis allows nurses and other practitioners to better understand their role in recovery and resistance they may encounter with patients, and to consider opportunities to better consider the origins of recovery in their practice.

2 | RECOVERY

Our intention here is not to offer an extensive historiography of recovery and recovery-oriented services; others have done so (Drennan & Alred, 2012; Pilgrim & McCranie, 2013). Instead, we aim to highlight the shifts in recovery's focus from its early radical origins. The early threads of recovery can be tied to the deinstitutionalization that took place in many Western nations, starting in the 1950s and continuing into the 1970s (Anthony, 1993; Ben-Moshe, 2020). Deinstitutionalization saw the widespread closure of large, typically State-run mental institutions, also referred to as asylums, with inhabitants transitioned to the community. Here, it was proposed, community-based services would better serve the needs of those living with mental health challenges. Ben-Moshe's (2020) critical genealogy of this process in the United States identified multiple contributing—and at times competing—factors responsible for the mass shuttering of these institutions. Among them included exposition of the harsh living conditions within asylums, class-action lawsuits, cost-cutting measures and new policies aimed at community living, the widespread use of new psychiatric medications, and political and social movements opposed to the carceral culture of these facilities. With the closing of institutions, those living with mental illnesses could enjoy the relative freedom of community living, supported through community-based services, with involuntary detention in psychiatric hospitals used only as a last resort.

Among those who had experienced involuntary detention and treatment within asylums, under the aegis of psychiatry, emerged a number of anti-psychiatry focused movements. In a North American context, Chamberlin (1984) described various organizations led by “former psychiatric inmates,” employing the language of incarceration to describe their experiences under conventional psychiatric care. Critical of the services and interventions offered by so-called mental health professionals, in both in-patient and community settings, these groups opposed the inflexible treatment programs, paternalism, over-reliance on psychiatric medications, and false sense of choice found therein. Those offering services were described as “far more undermining than supportive” (p. 57). Instead, these self-organized ex-patient “liberation fronts” proposed services and supports provided by peers, existing outside the conventional mental health system. Such alternatives were viewed as an explicitly political project, aimed at the promotion of independence and empowerment. Central to such projects was the spirit of cooperation and mutual support, such that conventional, State-sanctioned services were unnecessary, reminiscent of anarchist Peter Kropotkin's (1989) 19th century concept of *mutual aid*. Our focus here is on the North American context of recovery's origins. Convergent movements also arose in European nations, including those in the United Kingdom, influenced by figures like R. D. Laing and David Cooper (Crossley, 1998), and in Italy, influenced by Franco Basaglia (Menozzi, 2015).

These ex-patient, or psychiatric survivor movements emerged and developed within the context of various liberation movements of the 1960s. Ben-Moshe (2020) identified how these movements intersected with other liberation movements of the time. Noting the problematic history that psychiatric diagnoses played in the social control of various oppressed groups, ex-patient groups intersected with gay liberation, feminist, and black power movements. The pathologization and criminalization of homosexuality, identification of hysteria in “nonconformist women” (Ben-Moshe, 2020, p. 96), and the weaponization of schizophrenia diagnoses in black men (Metzl,

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2009) all illustrate these intersections. Out of these movements emerged some of the initial threads of recovery (Deegan, 1988).

Also emerging and developing in the 1980s was the psychiatric rehabilitation movement. Anthony and Liberman (1986) described the application of rehabilitation principles, already being used in medical contexts, to those living with mental health disorders. According to the authors, "the overall goal of psychiatric rehabilitation is to assure that the person with a psychiatric disability can perform those physical, emotional, social, and intellectual skills needed to live, learn, and work in the community, with the least amount of support necessary from agents of the helping professions" (p. 542). Psychiatric rehabilitation emphasized patient autonomy, but remained rooted in the realm of mental health professionals, which viewed a psychiatric diagnosis as a disability. While recovery initially emerged from ex-patients and liberation movements, it soon merged with psychiatric rehabilitation (Jacobson & Curtis, 2000).

2.1 | Recovery-oriented approaches

Perhaps the most oft-cited author of the emergence of recovery is William Anthony (1993):

> Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (p. 15)

In concert with this heavily cited definition is what that author proposed as a *recovery-oriented* mental health system. Such a system would marry the (ex)patient-led principles of recovery with the psychiatric rehabilitation model to redefine how mental health services could be offered. With a recovery-oriented approach came a codification of basic assumptions and identification of measurable outcomes. Elements like peer support, an emphasis on patient choice, and highly individualized approaches would dovetail into provider-based services. Here, we begin to see the shifts in recovery away from a user-led political movement toward greater practitioner involvement.

By the beginning of the 21st century, a recovery-oriented approach saw widespread adoption across multiple Western, English-speaking nations. For instance, Jacobson and Curtis (2000) outlined the adoption in the United States; McWade (2016) detailed its implementation in the United Kingdom; the Mental Health Commission of Canada (2012) identified recovery as a cornerstone for mental health services across the nation. Australia has also experienced widespread implementation of recovery in mental health settings (Ramon et al., 2007; Rickwood, 2004). The trajectory of recovery continued to shift from user-led approaches outside of psychiatry and formal mental health services toward greater practitioner-led implementation.

2.2 | Secure recovery

With the widespread adoption of recovery-oriented systems in conventional mental health settings and practices firmly entrenched, agencies and researchers turned their foci to the realm of forensic mental health. In such settings, individuals with mental health issues are held involuntarily under combinations of mental health and criminal justice legislation on account of crimes committed. For instance, in Canada, persons found "Not Criminally Responsible on Account of Mental Disorder" are detained in secure forensic hospitals until deemed suitable for release into the community (Latimer & Lawrence, 2006). The specifics of forensic services vary across jurisdictions, but typically include patients facing more restrictive lives than those in corrections (Holmes, 2002; Holmes & Murray, 2012) or conventional mental health settings, including indeterminate lengths of stay, activity restrictions, and imposed treatments (McKeown et al., 2016). Drennan and Alred (2012) outlined the implementation of recovery in such settings, differentiating it as "secure recovery" on account of the significant challenges a more restrictive setting on the goals of recovery. Such a manifestation of recovery in forensic settings represents perhaps the farthest departure from its radical origins, applied to involuntary and, at times, indefinitely detained patients.

Presented as a primarily practitioner-led movement, secure recovery is proposed as a patient-centered model aimed at "coming to terms with having offended, perceiving the need to change the personal qualities that resulted in past offending … and accepting the social and personal consequences of having offended" (Drennan & Alred, 2012, p. 15). Here, practitioners act as facilitators in a patient's "work" of recovery and transition beyond the stigma of both mental illness and criminality. Despite the challenges of the secure environment, authors across multiple jurisdictions have claimed success in meeting the goals of recovery in forensic mental health settings (Chandley et al., 2014; Livingston et al., 2012; McKenna et al., 2014).

3 | DELEUZE AND GUATTARI'S ASSEMBLAGE THEORY

The work of French philosophers Gilles Deleuze (1925–1985) and Félix Guattari (1930–1992) serve as a framework for the conceptualization of the origins, changes, and future directions of recovery. Deleuze had established himself as a leading French philosopher before joining forces in 1969 with Guatarri, a practicing psychoanalyst. The two co-authored works including *Anti-Oedipus* (originally published in 1972) and *A Thousand Plateaus* (originally published in 1980), the latter of which will inform this paper. Their work was controversial, breaking significantly with many philosophical

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traditions at the time, and became highly influential in the poststructuralist philosophical perspective (Adkins, 2015).

A central concept of Deleuze and Guattari's (1987) *A Thousand Plateaus* is that of an assemblage. An assemblage, according to Adkins (2015), is the answer to the question "what is a thing?" But an assemblage—a thing—can never be a permanent, static entity; instead, they "are to be thought as concrete collections of heterogeneous materials that display tendencies toward both stability and change" (Adkins, 2015, p. 14). At any given moment, an assemblage may appear as a stable entity; however, any assemblage is composed of multiple intersecting lines that change in composition over time and space. All these intersecting lines which comprise an assemblage themselves exist on a continuum between opposing poles, or tendencies. Deleuze and Guattari (1987) introduced a number of opposing tendencies (concepts) that are helpful in conceiving recovery as an assemblage. These include, and will be explored further below, the tendencies between nomad and royal science, the Wm and dSm, smooth and striated space, and finally, deterritorialization and reterritorialization. The origins of recovery, rooted in multiple antipsychiatry and ex-patient movements, looked much different than today's codified, provider-led, institutionally sanctioned recovery; assemblage theory provides a unique and relevant lens from which to critically examine these changes.

To begin, let us consider the origins of recovery in the context of the tendencies of royal and nomad science. Royal science deals in ideal essences, in universals and stabilities, and is embraced and practiced by government agencies, major research universities, funding agencies, and so on—what would typically be considered the dominant traditions of science. At the opposite end of the continuum lies nomad science. Nomad science lies exterior to royal science, it rejects its traditions in an effort to create something new. Deleuze and Guattari (1987) use the concepts of a circle and roundness to differentiate between these opposing tendencies. State science is concerned with the precise, mathematical, and concrete ideal of a circle, whereas nomad science is more interested in roundness—an imprecise and fluid concept. According to Adkins (2015), "for nomad science the circle is not what roundness necessarily or even ideally tends toward" (p. 12). It is messy, fluid, and uninterested in universal concepts. Nomad science basks in experimentation, it produces "minoritarian or delinquent knowledge."

The early origins and manifestations of recovery, rooted in anti-institutional movements (Howell & Voronka, 2012), emerged as a rejection of the royal science approaches that typically provided mental health services. Chamberlin's (1984) overview of what is described as the "ex-psychiatric inmates' movement" highlights the various nomadic science approaches that emerged in the aftermath of deinstitutionalization. The author described "program models that exist outside the organized mental health system," going on to State, "it is only outside the mental health system that self-help and mutual support can flourish" (p. 56). These user-run programs were reported to offer appropriate supports, in contrast to those of the traditional mental health system that are described as "undermining" (p. 57). Recovery, as a nomad science, emerged from these groups. According to Deegan (1988), "the recovery process cannot be completely described with traditional scientific, psychiatric, or psychological language" (p. 12).

In addition to the royal/nomad science dualities, let us next consider recovery within the context of Deleuze and Guattari's (1987) concepts of the dSm and Wm. Again, the tendencies of interior and exterior apply to these concepts. Beyond what we might typically consider the State—governments, legal systems, police, militaries, and so on—Deleuze and Guattari (1983) described the dSm as a system of power "everywhere stamping the mark of the *Urstaat* on the new state of things" (p. 218). The dSm is repressive and aimed at the regulation of behaviors, "eating up and assimilating the social networks with which it comes into contact" (Robinson, 2010, para. 4). That which exists exterior to its grasp must be absorbed or destroyed. The Wm exists outside the State apparatus, it encompasses any thing or group that fails to adhere to the interior habit of thinking of the State. The autonomous Wm "is an assemblage directed against the State"; it seeks to undermine the State by breaking down channels of power and replacing "striated" (regulated, marked, and coded) spaces with "smooth" ones (spaces occupied by resisting persons and groups; Robinson, 2010, para. 8). Therefore, it can be rightly said that the war-machine is actively involved in the practice of everyday resistance (Deleuze & Guattari, 1987; Robinson, 2010). Adkins (2015) offers the "Occupy Movement" as an example of the Wm.

Morrow and Weisser (2012) identified a "resistance to the dominance of psychiatry" (p. 28) as a central tenet of recovery in its early stages. Those engaged in the work and activism of recovery were typically persons who had experienced the programs, restrictions, and, at times, incarcerations of psychiatry. Mental health and mental illness were thought within the model of psychiatry, as extensions of the dSm. In contrast, the Wm, according to Deleuze and Guattari (1987), consists of "local mechanisms of bands, margins, minorities, which continue to affirm the rights of segmentary societies in opposition to the organs of State power" (p. 360). Local groups of ex-patient collectives, operating entirely outside the realm of medical authority, refused to be viewed within the normal/abnormal dichotomy espoused by psychiatry (Deegan, 1988). Instead, they wished to live their lives as they choose, completely outside the authority and expectations of the despotic (psychiatric) State apparatus. Damsgaard et al. (2021) noted the difficulties of recovery within institutional structures. Not only were the Wms of early recovery movements operating in spaces outside of conventional mental health services, their views of what comprised appropriate lives and conceptions of mental health existed outside the medical and psychiatric domains.

Finally, let us consider Deleuze and Guattari's (1987) concepts of striated and smooth space when constructing the assemblage that is the early forms of recovery. Again, these two tendencies form opposite metaphors. Striated space, as expected, is aligned with the dSm and royal science. It is rigid and homogenous "by making everything subject to the same rule" (Adkins, 2015, p. 232). It eliminates differences. In contrast, smooth space is fluid and

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heterogeneous, it is comprised of difference, it is where change is possible. Deleuze and Guattari use the games Chess and Go to illustrate the differences between striated space (and with it, the dSm) and smooth space (and with it, the Wm). In Chess, individual pieces are coded; they can only move in certain ways within the static grid of the game board—"Chess is a game of State" (Deleuze & Guattari, 1987, p. 352), existing within a striated space. In contrast, the simple disks of Go have "no intrinsic properties, only situation ones" (p. 353). Go is a game of the Wm, existing within a smooth space.

The asylums and State-run psychiatric facilities to which many of the early antipsychiatry, ex-patient movements objected certainly constitute a striated space. These "total institutions" which Goffman (1961) so famously described, restricted the movements, choices, and lives of their inhabitants. The deinstitutionalization of those from within the asylums, in many ways, promised a shift to the smoother space of community existence and reintegration. In reality, however, those who used community-based services, such as outpatient programs, group homes, and a new reliance on psychotropic medications, described their undermining and iatrogenic effects (Ben-Moshe, 2020). These treatments and programs still existed within the striated space of the dSm and royal science. In contrast, user-led programs and support groups existed within a smooth space. According to Chamberlin (1984), support groups and collectively run organizations sprouted up across North America in the 1970s. These heterogeneous organizations, embedded in a spirit of activism were fluid and flexible, able to adapt to meet the ongoing needs of their membership. Again, these spaces existed outside, in a very intentional manner, to the services offered by the State and other State-sanctioned organizations. They created something new, within a smooth space.

In considering recovery, in its early stages, as an assemblage, the three continua explored above comprise some of its many intersecting lines. The antipsychiatry and psychiatric survivor movements of the 1960s and 1970s rejected the dSm embedded in the psychiatric services offered post-deinstitutionalization. They created something new—a form of nomad life that existed external to the overcoded injunctions of the striated spaces imposed by the psychiatric apparatus. Those who created these new programs and services were part of the Wm, again, external to the psychiatrists, service providers, and institutions offering conventional programs. These new services created, typically by and for those who rejected typical psychiatric and mental health practices, existed in smooth spaces, in stark contrast to the very striated spaces of psychiatric facilities, group homes, and provider-led programs.

Yet, as Deleuze and Guattari remind us, no assemblage ever exists purely at one end of a continuum. Instead, an assemblage exists at the intersection of multiple lines, all of which lie somewhere between opposing ends of the spectrum. In the early iterations of recovery, as an assemblage, it tended toward the nomad science, the Wm, and the smooth space logics, all of which pulled it in the direction of change (and away from stasis and capture). However, over the past years, those tendencies have shifted significantly.

4 | STRIATION OF RECOVERY

The origins of recovery emerged through the creation of something new. Out of psychiatry and psychiatric services, ex-patients and others formed a Wm, moving from striated to smooth spaces. Deleuze and Guattari described this process as "deterritorialization." Deterritorialization exists on a continuum, with reterritorialization as its opposite pole; recovery deterritorialized into a smooth space, a Wm, practicing nomad science. This is how we create something new. The opposing tendency, toward stasis, is reterritorialization, where the dSm and royal science work to reclaim—or appropriate—these nomads, bringing them back into striated spaces. Adkins (2015) summarizes the relationship between royal and nomad science as "the story of the State appropriating nomad science for its own ends … and legitimating that use through the methodologies of royal science" (pp. 197–198). According to the dSm, nomads are disruptive and cannot remain external, they must be re-incorporated. The trajectory of recovery over the past years has followed this path, from the smooth to the striated.

A significant development in this shift is the development of recovery-oriented services. William Anthony, oft-cited and considered by many to have defined the modern recovery movement, was an early proponent of psychiatric rehabilitation (Anthony & Liberman, 1986). With rehabilitation becoming a growing focus within biomedicine, many began to apply these principles to psychiatric diagnoses. Conceptualizing a psychiatric diagnosis as a form of disability, psychiatric rehabilitation worked to address these disabilities, with the support of professionals. In his heavily cited paper proposing recovery as "the guiding vision of the mental health service system in the 1990s," Anthony (1993) praised the work done by community support systems, and proposed a marriage of these services with psychiatric rehabilitation to form a "recovery-oriented mental health system" (p. 16). Here, we see the process of reterritorialization. Psychiatric rehabilitation, rooted in the dSm and royal science, begins striating the smooth space of recovery. Mental health professionals, embedded within conventional service organizations, begin to partner with those offering exterior services. A remedicalization of recovery convenes. Howell and Voronka (2012) described this as a "re-figuring" that would "deny the possibility of a kind of recovery that would place patients… outside the remit of medical authority" (p. 2).

By the 21st century, this shift along the continuum had progressed significantly. Recovery emerged as a specific policy amongst mental health services across the United States (Jacobson & Curtis, 2000). It became official mental health policy In the United Kingdom (McWade, 2016) and Australia (Slade et al., 2008) and has been officially recommended as policy in Canada (Mental Health Commission of Canada, 2012). It has stretched even into highly restrictive forensic settings. Questions of how to implement recovery into mental health services arose. Researchers and policymakers developed lists of common characteristics of recovery (Slade et al., 2008). Assessments of the viability and value of recovery implementation accompanied by vision statements. Task forces were

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assembled. Measurable treatment outcomes were developed. Service providers, including nurses, were educated on this new model of care. The "consumers" (Jacobson & Curtis, 2000) of recovery services—those (ex-)patients who originally enacted recovery—became stakeholders, with these consumers and their family members "recruited to serve on the boards of service organizations" (p. 5). These contributions came to be described as political action, a far cry from the more radical movements of the 1960s and 1970s. Here we see royal science and the dSm appropriating previously nomadic recovery, bringing it back into striated spaces.

In recovery-oriented mental health services, service providers, including nurses, psychologists, psychiatrists, and other medical professionals, serve as facilitators, or guides in a person's recovery journey (Anthony, 1993; Chandley et al., 2014). Survivors, or ex-patients become patients again, or clients, or service users; all of these terms suggest an interiority to the services provided. Patients are viewed as "critical stakeholders" (Jacobson & Curtis, 2000, p. 5) within the recovery process, no longer the sole participants. According to McWade (2016), recovery had been "taken over by the very institutions it sought to challenge" (p. 64). Morrow and Weisser (2012) criticized that the distance recovery had moved from its activist roots, suggesting that it had come to be dominated by the very professionals from whom it had originally worked to separate. In fact, the authors suggested that recovery had become harmful to many it purported to support. In particular, the role of peer support in modern-day recovery was problematized. In its original manifestations, recovery operated via peer support in community-based services, external to formal mental health services. However, peer support now, according to the authors, is merely token participation by poorly compensated workers who "are being integrated into pre-existing bureaucratic structures," a term they go on to describe as "the corporatization of peers" (p. 37). The new experts of recovery are no longer patients, but the practitioners themselves (Howell & Voronka, 2012).

Perhaps the realm in which recovery has shifted most drastically from its origins—and become most striated—is within secure forensic mental health services, what Drennan and Alred (2012) described as "secure recovery." In such environments, patients are involuntarily detained within corrections-like psychiatric hospital environments on account of both criminal convictions and psychiatric diagnoses. Such environments most resemble the "total institutions" that Goffman (1961) critically examined in his work on asylums (Holmes & Federman, 2006)—the very modalities of mental health treatment that led to both deinstitutionalization and the early geneses of recovery. Patients are detained for lengthy periods, if not indefinitely (Latimer & Lawrence, 2006), where the focus of treatment is on both their mental health concerns and criminal behaviors. Within such environments, multiple authors have suggested that the aims and goals of recovery can be achieved, albeit in a manner appropriate to the setting (Chandley et al., 2014; Livingston et al., 2012; McKenna et al., 2014). Central to this form of "secure recovery" is the promotion of hope, a focus on patient autonomy (within the confines of the institution), and meaningful engagement, all facilitated via positive relationships with services providers—primarily nurses—who act as "guides" in a patient's recovery "journey" (Chandley et al., 2014; Drennan & Alred, 2012). We have offered our critique of secure recovery elsewhere (Johansson & Holmes, 2022); the goal of recovery in this iteration focuses on the production of an ideal neoliberal subject. Patient progress and potential for community release become contingent on both participation and advancement in a narrowly defined conception of recovery success. In fact, as Young (2011) described, recovery in such settings is at risk of being imposed. When we consider recovery in this context, it is nearly unrecognizable from the goals and conceptions of the concept originally proposed in the 1960s and 1970s. It has been reterritorialized by the dSm and its myriad of apparatuses and the practitioners of royal science: the nurses, psychologists, and psychiatrists working within these secure settings.

5 | RECOVERY: WHAT NEXT?

With this dramatic shift in the focus and practice of recovery over the past half a century, many scholars and patients question its future prospects. Crowe (2022) criticized the existence of recovery within the hierarchies of service provisions, and called for a "horizontal" model that recenters the person living with mental health issues. Thornton and Lucas (2011) called for recovery to be divorced from the biomedical model. Hunt and Resnick (2015) described the professionalization of recovery as a "well-meaning theft-through-adoption" (p. 1236). With this professionalization, the activism originally at the heart of recovery faded. These authors suggest a return of recovery to an ethos of activism. Morrow and Weisser (2012) called for a reinvigoration of recovery, with psychiatric survivors leading this movement. If we consider recovery as an assemblage, what these authors are proposing is to shift its composition back toward the smooth space that originally defined the concept, to once again deterritorialize recovery.

Others, however, are less optimistic about the prospects for recovery to return to its origins. Crowe (2022) questioned why, after decades of implementation, recovery has had minimal impact on the outcomes of those using services. The professionalization of recovery, back to the very institutions it originally rejected signals a return of coercive practices that harm, not help, many patients. McWade (2016) described "the paradox faced by people… who are promised individual freedoms with a system that increasingly threatens those freedoms" (p. 76). Ben-Moshe (2020) described the "carceral logic" of involuntary detention and other mental health services that have emerged post-deinstitutionalization. Such logic suggests that many of the re-imagined services proposed to help those who would have, in the past, been institutionalized continue to bear the same tendencies they purport to have left behind. Though recovery-oriented mental health services aim to provide patient choice, autonomy, and hope, they still exist within a highly restrictive framework of the dSm. This is perhaps most apparent in the "secure recovery" of forensic mental health services. As we have argued

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elsewhere (Johansson & Holmes, 2022), secure recovery cannot escape the correctional context in which it exists, and it only serves to produce patients who can fit within the expectations of proper neoliberal (humanist) subjectivity—that of the productive member of society. Those who do not conform to such expectations are left to languish within the institution (McKeown et al., 2016); in effect, only those who exit the interiority of the forensic environment must still exist interior to the greater expectations of myriad State apparatuses. Recovery has become so embedded within institutions, policies, and patient expectations—it has become so striated and appropriated by royal science—that we doubt it can return to its origins. When viewed as an assemblage, recovery has become completely different—it has become heavily stratified—compared to what it once was.

What has emerged in recent years is a new form of resistance to psychiatry and other mental health services, typically referred to as the "mad" movement, mad pride, and associated mad studies (Beresford, 2020; Farber, 2012; Lefrançois et al., 2013). Like the early stages of recovery, this "mad" movement lacks a singular, cohesive definition. The reclamation of the term "mad," a stigma-laced pejorative, intends to reject the biomedical language typically used to describe those living with mental illness (Beresford, 2020). It primarily consists of those who have experienced treatments deemed harmful from mental health providers and aims to build a movement of support and acceptance outside these systems. Such a movement, as Deleuze and Guattari (1987) would suggest, is one of the Wms, rejecting the striated space of royal science (psychiatry, recovery, and other mental health services), creating a new, nomad science in the smooth space exterior to the dSm. A new assemblage has formed, leaving recovery behind. Time will tell if this movement also becomes reterritorialized in full.

6 | CONCLUSION

Our intention here is not to demonize recovery, but instead to trace its trajectory over the past half-century within the context of Deleuze and Guattari's (1987) assemblage theory. Such a lens provides a critical examination of both change and stasis in mental health nursing practices. The early stages of recovery as a political movement signaled a rejection of mental health services deemed unhelpful, at best, even harmful by patients. The recovery-oriented services that evolved out of these early stages of recovery signaled a shift in nursing practices that can certainly be viewed as an improvement. A change in practices—and in thinking—occurred. Yet, over time, as these practices became more established, more codified, and more institutional, a stasis developed. Recovery had been reterritorialized. Practitioners, including nurses, wrestled ownership of recovery away from patients. We argue that the seeming benevolence and patient-centeredness of recovery should not be taken for granted. If and when nurses encounter patient resistance to recovery, this shift in the shape of recovery should be considered. The re-emergence of a new movement, this "mad pride" movement, should provide a lesson to nurses that the services we provide have become unacceptable to many of our patients.

For those of us who continue to practice in recovery-oriented (forensic) mental health services, Deleuze and Guattari's (1987) assemblage theory offers guidance. An assemblage, they argue, is never fixed. It consists of multiple intersecting lines, or tendencies, and cannot exist entirely at one end of all these continua. Nurses, working within multiple assemblages, bear the capacity to shift these tendencies back toward the smooth, nomadic tendencies of the early recovery movement. Perhaps nurses can shift recovery back in the direction of nomad science. What does this look like? It looks like a critical reflection of the proposed outcomes of recovery for our patients; do they push the patient toward the lives we expect of them, or do they embrace difference? Do they view a patient's mental illness, as Ben-Moshe (2020) described, "as a deficit, something in need of correction, medically/psychiatrically or by the correction industry, but not as a nuanced identity from which to understand how to live differently" (p. 1)? It looks like a critical examination of institutional rules and regulations, and consideration of whether strict adherence is necessary. In forensic settings, McKenna et al. (2014), described nurses taking "calculated risks" with patients, wherein a flexibility of regulations was exercised for the benefit of patients. It looks like nurses asking the question, "how can I smooth this space" in practice. Alternatively, nurses should look to the newly emerging "mad pride" movement as a guide to inform our understanding of how patients wish to be perceived and treated. And to recognize that what may be best for patients may also exist entirely outside of what we can offer.

AUTHOR CONTRIBUTIONS

All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors. Both authors are in agreement with the manuscript.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no data sets were generated or analyzed during the current study.

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