

Recovering mental health in Scotland. 'Recovery' from social movement to policy goal.

Jennifer Smith-Merry
Steve Sturdy
Richard Freeman

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1. Executive Summary.

This report results from a project examining the development of recovery as a policy goal for mental health in Scotland. The research is part of the European Commission funded KnowandPol project which investigates knowledge in relation to health and education policies within eight European countries. The work of the Scottish Health team throughout the project has focused on mental health policy in Scotland. Our work reported here represents the second of two case studies for 'Orientation 2' of the project which seeks to examine the way knowledge is used and produced within the processes of a particular policy or public action.

This report tells the story of the development of recovery in Scotland as understood by key informants involved in mental health and repeated within official documents. The story we are told leads us from the psychiatric rehabilitation movement in the 1950s, to service user organising in the 1970s and 1980s and on to the emergence of recovery into policy via the Mental Health Commission in New Zealand in the 1990s. From here the concept moved to Scotland through personal and organisational links where a group of key actors was instrumental in its move into Scottish Government policy. From within the Scottish Government the concept of recovery shifted as it was applied within key technologies such as the Scottish Recovery Indicator tool, Wellness Recovery Action Planning and Peer Support. Our story finishes with a challenge by service users who are pushing for the concept to be taken yet further still. Theoretically we position the story of recovery in Scotland as an example of a successful social movement and highlight key structural factors which facilitated its adoption within policy.

2. Introduction.

This report examines the development of recovery as a policy goal for mental health in Scotland. This research is part of the KnowandPol project which examines the way that knowledge functions in relation to policy within different European countries. The project draws on research by six research teams working on education policy within their respective countries and another six working on health policy. This report derives from work done by the Scottish health team where our research throughout the project has focussed on mental health policy in Scotland. This phase of the project is the second of two case studies which examine knowledge as a regulatory tool in relation to a policy/public action. Specifically the research from this phase investigates the following general questions:

- Where do the actors involved in the public action speak from? Where do they come from? Who do they talk to? What kind of relationships are they involved in?

- What do the actors involved know? What do they think they know? What types of categories do they use in their narratives? How do they assemble ideas, actors, devices, events, values in their story?
- What are the common stages/events emerging from the narratives?
- Why is it that such or such representation of reality comes to structure public action at a given time period in a given country/sector?

We have chosen to address these questions by examining the development of 'recovery' as a policy goal within the sphere of mental health work in Scotland. Our research draws on documentary analysis and a set of interviews with key actors within the field. We have chosen to present the data using the narrative approach adopted by historical sociologists.

3. Methodology.

Our research brings together interview data from nine interviews and analysis of primary texts around the development and institutionalisation of recovery in Scotland. We entered all of our data into the data management programme Nvivo and then hand-coded the data according to actor and theme. We temporally ordered the data and constructed from it a narrative of the development of recovery in Scotland. From our data we were able to identify key points and technologies which characterise key stages and phases in the development of recovery. In doing so we have drawn on the narrative approach to data as utilised within historical sociology. This approach to data uses narrative "to examine the interconnectedness of human agency and social structure and temporality of historical events in processual ways" (Gotham and Staples, 1996:482). In utilising this narrative approach it is important to realise that the story that we told is not 'what happened', but rather a reflection of our synthesis of what has been remembered and related by actors in the field and within key documents (Gotham and Staples, 1996:483). Once the narrative was written we looked back over the story that had been told and tried to conceptualise the data in relation to different theoretical perspectives. As the story of recovery emerged through our analysis we were struck by the extent to which the development of recovery in Scotland resembled the development of a social movement. We have therefore chosen to examine the data in relation to social movement theory and specifically Snow and Benford's work on framing. This approach guides the concluding discussion of our data within the report.

4. Results.

4.1 Defining recovery.

We began all of our interviews by asking respondents to define recovery. The creation of an adequate and flexible definition of recovery and discussion of the extent to which this is in fact desirable has long been a concern for those interested in work on recovery (Bradstreet, 2004). The definition of recovery is important because it sets a boundary around which actions policy making on recovery might encompass. Our respondents offered a variety of definitions of recovery. Some respondents focused on the multiplicity of definitions and the broadness of the idea, which makes it very difficult to define:

“Recovery is living. I think it’s as simple as that. I think we’ve complicated it. I just think recovery is getting on with life....I don’t think anybody knows [the definition] for a collective. I think every individual knows the answer for themselves.”
- (Community 1)

“It’s a construct, a concept that has been used as part of an ideology. It’s people’s lived experience, which is distinct from concepts and ideology. And it’s an agenda, a policy agenda. And it’s a topic for research. Multi-faceted... There would be people’s individual understandings, which would be an infinite number of understandings.... Living well with or without, in the presence or absence of, mental distress, illness, spiritual crisis etc etc seems to be the key.”
- (Community 2)

“It is a journey, a process whereby people are able to achieve the best they can do. So it’s a focus on personalisation, a focus on meaning, purpose in life, fulfilling one’s potential, processes of self-management. And also being able to participate in processes of citizenship.”
- (Practitioner 2)

Others, while also emphasising the broadness of the concept, spoke of recovery in terms of the behaviour of services in relation to service users:

“The common issue around recovery is really around partnership working and key elements are choice and responsibility and shared responsibility. But recovery generally is giving individuals choice, opportunity and support to find their own way.”
- (Practitioner 1)

“...recovery all starts from the experience of recovery. Of people recovering from mental health problems however they choose to describe them. That’s the absolute starting point – the fact that that can and does happen. What’s happened here is and elsewhere is that the concept of people recovering and controlling their own lives has been used as a driver for change in the wider

society and probably most particularly in mental health services. So it is using personal experience as a system of changing and that's a very simple answer to a very complex question." - (NGO 1)

"The questions that services run themselves by is changing. I think that's what recovery is. I think recovery in its late stages is an early philosophy in a way – a bit Hegelian. So I understand the concept of being able to live with or without the symptoms of mental illness, but really I think it's a general shift in the attitude of the system. I think that's what recovery is.... Recovery is 'you are doing the right thing for you at the right time'." - (NGO 2)

What all of these definitions share is the idea that recovery as a concept is very subjective and dependent on the life situation and history of each individual service user and practitioner. Some of the definitions also share the idea that recovery is a process, or journey, toward a shift in consciousness and practice. Recovery is also viewed as a value – a value which centres around choice and the centrality of the individual. We will reflect more on the various definitions of recovery enacted over the history of work on recovery both within Scotland and elsewhere and revisit the concept in our concluding discussion.

4.2 Pre-history: ancestral roots of recovery.

That which is currently termed 'recovery' articulates a set of concepts and practices which has, according to our respondents, gradually developed over the past 100 years. Two of our respondents spoke of the link between the concept of recovery and the movement towards self-help groups like Alcoholics Anonymous and Abraham Low's 'Recovery, incorporated' in the 1930s (NGO 2¹; Government 1). Sowers (2005: 758) comments on what recovery has meant for those involved in the self-help groups of Low's Recovery Inc:

"It offers a peer assisted healing program that focuses on changing thought processes, developing autonomy, and regaining productive and satisfying lives. Like the 12-step approach, it attempts to empower people to take responsibility for managing their illness or disability"

¹ Throughout the report we refer to respondents by the category which most represents the position they were speaking from throughout the interviews and a numerical identifier, such as 'NGO 2'. Although we are aware that individuals take up multiple positions in the mental health community, for example as both government worker and community activist or NGO worker and service user, we have had to make these distinctions for clarity of referencing.

Though rooted in Low's work as a psychiatrist, the main focus of this approach has been on peer support, with 'recovery' as a continuous journey facilitated by frequent participation in structured self-help groups.

Other respondents linked recovery to more recent developments, especially the psychiatric rehabilitation movement and the rise of the service user² movement from the 1960s (Community 2; NGO 1; Community 1; NGO 2; Government 1).

Psychiatric rehabilitation had the following goal:

"In essence, the overall mission of psychiatric rehabilitation is to ensure that the person with the psychiatric disability can perform those physical, emotional, and intellectual skills needed to live, learn, and work in his or her own particular community, given the least amount of intervention necessary from agents of the helping professions." - (Anthony, Kennard, O'Brien and Forbess, 1986:249-250)

Jacobson and Curtis (2000) note that the difference between the notion of recovery as presented within psychiatric rehabilitation and that espoused by service user groups was the former's focus on recovery of "functional ability" as opposed to the service user focus on recovery as both a political and personal goal, defined as "empowerment".

Specific service user groups from the UK, New Zealand and Canada were emphasised as being integral to the development of recovery ideals (Community 1; Community 2; Government 1). Writing in the early 1990s Anthony (1993:527) drew on the work of service users to offer the following definition of recovery:

"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 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."

The increasing mobilisation of service user movements eventually developed an environment where service users were "increasingly sharing their experiences, sharing their stories, becoming the focal point of efforts to improve mental health and mental health outcomes both here and abroad" (NGO 1). This dialogue opened up further spaces where the voices of those who have experienced mental ill health could be heard and eventually contribute to policy making (NGO 1; NGO 2).

² In this report we use the term 'service user' rather than 'consumer' to refer to those with a lived experience of mental ill-health as this is the term most widely used in Scotland to refer to this group of people.

In addition to the work of the service user movement respondents identified the work of government bodies within several countries as important in the development of recovery in Scotland: England, the US and, most prominently, New Zealand (Government 2; Government 1; Practitioner 1; NGO 1; Community 2). Jacobson and Curtis (2000) offer an account of recovery as expressed in the work of different service contexts in the US at the end of the 1990s. This account demonstrates a range of service responses based on an understanding of recovery very much in line with that espoused in the quotation by Anthony (1993) above. These service responses ranged from services which would include the word 'recovery' in their name but make no practical changes, to services which were attempting to implement some of the more challenging orientations of recovery, such as service user led service provision (Jacobson and Curtis, 2000). Four of our respondents specifically identified earlier work in New Zealand as important for the development of recovery as a policy goal in Scotland (Government 1; Practitioner 1; NGO 1; Community 2). In New Zealand recovery became a national guiding priority for the provision of mental health services. This work will be discussed in depth in the next stage of our report.

The manifestations of 'recovery' central to these movements created a history of practices which contributed to the development of recovery as it is now implemented in a Scottish context (Government 1). This history made current work on recovery in Scotland possible.

4.3 Movement to policy: New Zealand.

The idea of recovery was initially promoted in New Zealand through the service user movement but first moved into policy shortly after the development of the Mental Health Commission in 1996 (O'Hagan, 2004). The Mental Health Commission was to function "as a catalyst to improve performance and lift the priority given to Mental Health in New Zealand" (Mental Health Commission, 2007, p.1). One of the first documents written to guide the work of the Commission was the *Blueprint for Mental Health Services in New Zealand: How Things Need to Be*. This document first introduced recovery into the work of New Zealand's mental health services (O'Hagan, 2004; Mental Health Commission, 2007). The place of recovery in the document was seen as important because it was an official document guiding the work of the sector:

"[recovery] is in the document and because the document became the Mental Health Commission's bible it was agreed to by the Ministry as the Blueprint and there was a sign up."
- (Government 1)

The executive summary of the *Blueprint* articulates what a 'recovery approach' entails:

- “The focus of this Blueprint is on a recovery approach in service delivery. This approach is consistent with the guiding principles of the Strategy, which state that services must empower consumers, assure their rights, get the best outcomes, increase their control over their mental health and well-being, and enable them to fully participate in society. This focus on recovery reflects the shift of thinking which is happening throughout the sector.
- The recovery approach requires mental health services to work towards righting the discrimination against people with mental illness which occurs within services and in the wider community.”

- (Mental Health Commission, 1998, p.vii.)

The first Chair of the Commission, Barbara Disley, consulted widely with service users and it was a group of service users who ensured that the *Blueprint* included recovery as a key guiding concept (O’Hagan, 2004; Government 1; Community 2). Amongst these service users was Mary O’Hagan who later became a Commissioner with the Mental Health Commission. O’Hagan (2004) reflects that the concept of recovery which they were initially working with had been imported from America. However this take on recovery did not sit well with the work they wanted the concept to do in New Zealand (O’Hagan, 2004; Community 2; Government 1). They therefore needed to adapt recovery concept to their own needs:

“So, we added quite a lot of content to the recovery ‘container’ that we’d inherited from America. We were confident that New Zealanders would as a result come to associate the label ‘recovery’ with the fuller ‘container’. Some service users in New Zealand still don’t like the word ‘recovery’ but I have not heard one of them object to the way we have defined and interpreted it.”

- (O’Hagan, 2004)

O’Hagan (2004) felt that recovery as institutionalised in an American context was focused too much in the work of psychiatric rehabilitation and “did not place a great deal of emphasis on challenging the veracity of or the dominance of the biomedical model in mental health services.” It also did not pay enough attention to the “values” of recovery as interpreted by the service user movement which were described as a, “spotlight on human rights, advocacy and on service user partnerships with professionals at all levels and phases of service planning, delivery and evaluation” (O’Hagan, 2004). This ‘New Zealand’ concept of recovery was articulated through the *Blueprint* and the work of the Mental Health Commission and was operationalised through the performance of New Zealand’s mental health services. Interestingly a prominent aspect of recovery work in New Zealand has been the development of a narrative research project in which researchers, supported by the Mental Health Commission, investigated what recovery meant to New Zealanders. This report, “*Kia Mauri Tau!*” *narratives of recovery from*

disabling mental health problems, was released in 2002 and was cited as an influential document by several of our respondents (Government 1; Community 2; Lapsley, Nikora and Black, 2002). This narrative project worked to define recovery and developed a specifically New Zealand version of recovery, thereby enforcing a conceptualisation of recovery which the movement could build itself around.

4.4 Recovery comes to Scotland.

Throughout the 1990s there was a growing prominence of the ideas associated with the term recovery within the service user movement in the UK, although the term was not widely used or known during this time (Community 1). Key to the growth of the concept within Scotland was the work of individual services users and groups such as Ron Coleman, the Hearing Voices Network and the Highland Users Group (NGO 1; Community 2; NGO 2; Community 1). The concept of recovery developed prominence through discussions within service user networks about concerns that the services they were using failed them on a number of levels (e.g. HUG, 1998). A 1998 report by the Highland Users Group (HUG) highlighted what individuals wanted from a 'good' mental health service:

- "be able to secure their rights to benefits, good housing etc.
- have the presence of a caring person in their lives
- get well
- have enabled individuals to influence their care and treatment
- be recognised and treated as a person
- be treated better by others
- be able to maintain their chosen lifestyle
- be able to accept their illness and cope better with it
- have a choice of services
- feel better about themselves
- be more informed about their illness and what to expect from services and treatments
- be given care in both the short and long term
- get help quickly when in crisis

- to be more in control
- have access to people who care” - (HUG, 1998)

Many of these ideas are common to the other definitions of recovery being used in both service user groups and service provision at this time in both the US and New Zealand (e.g. as discussed in Jacobson and Curtis, 2000; O’Hagan, 2004). Recovery could be easily taken up because it brought together these concerns within one broad concept. For Scottish service users recovery was seen as necessary because it had been forgotten and excluded to such an extent that most people diagnosed with mental ill-health did not think that recovery was possible (Community 1). Recovery had become totally alien to the mental health system (Coleman, 1999). Ron Coleman’s book *Recovery: an alien concept* was first published in 1999. In it he articulated why recovery was necessary, what recovery was and how to do it (Amering and Schmolke, 2009). Amering and Schmolke (2009:62) write that for Coleman recovery “does not mean mere stabilization, but rather the achievement of health.” Mentioning the work of Ron Coleman one respondent commented: “Ron Coleman has been a kind of lynchpin of recovery in the world” (NGO 2). Recovery in Scotland therefore grew out of a movement which was primarily based around a network of service users. This group of service users was gradually augmented by individuals working within advocacy groups.

Several of our respondents spoke about work they encountered from New Zealand in the 1990s as being key to the development of the word ‘recovery’ as encompassing the principles with which they associate it today (NGO 1; Practitioner 1; Community 2). One respondent reflected that New Zealand was viewed as a natural comparator because they were “structurally and geographically” similar (NGO 3). From 2000-2003 several people from Scotland were involved in visits to New Zealand where they learnt about what was happening in relation to recovery. One of our respondents spoke of returning from one of these trips in December 2000 and initiating a meeting with individuals working within the Mental Health Division of the Scottish Executive (Community 2). While there was interest in recovery expressed by those from the Mental Health Division they were unwilling at that stage to invest in work on recovery because of their unfamiliarity with the concept and concern that it would not be effective:

“My recollection is they heard it and looked at these beautiful materials and said, ‘but does it work?’ and [I] said well [I] didn’t know and they said ‘well if you find out come and tell us and we’ll be interested’. So that was that.” - (Community 2)

Other discussions happening at this time outside of the Executive proved to be more effective. Service providers, researchers, NGOs and service users were getting together to talk more about recovery work being done by Scottish service users (Community 1; NGO 1; Community 2; NGO 2). Respondents spoke of the importance of the Visions and Voices conference held in Dundee, where a group made up of these interests met one

night to discuss recovery (Community 2; Community 1; Scottish Development Centre for Mental Health, 2002). By the end of the evening they had decided to develop the Scottish Recovery Forum, which would eventually become the Scottish Recovery Network. This group, which included representatives of service user groups such as the National Schizophrenia Fellowship, ENERGI in Fife and the Hearing Voices Network, Gregor Henderson from the Scottish Development Centre for Mental Health (SDC), Simon Bradstreet from the Scottish Association for Mental Health (SAMH) and Nigel Henderson from Penumbra, continued to meet (Community 1). The aim of the Scottish Recovery Forum was to create a network "to help create and promote further opportunities for sharing experiences, learning and understanding the recovery process in Scotland" (SEHD, 2002). This would fulfil the need to get "momentum" going around work on recovery (Scottish Development Centre for Mental Health, 2002).

Important work raising the profile of 'recovery' in Scotland was also taking place at this time through service user groups and NGOs. One respondent, at that time a mental health worker, spoke about his first exposure to the concept of recovery at a conference jointly hosted by SAMH and service user groups in Glasgow in 2004:

"People from the Hearing Voices Network started talking about their experience of using services, how everything about their life had become symptomatic and diagnosis was reflected – they only lived through diagnosis and in some way people interact with them through diagnosis....The conference instigated a lot of self-reflection for service providers." - (NGO 2)

For many of those working in mental health the idea of recovery strongly resonated with the ideals which they wanted to practice through their work:

"...[recovery] connects with what we think is wrong with mental health services, what we want to be doing with them.... When I do recovery training...it's not as though people are learning anything new, they are kind of unlearning what it is they have been doing." - (NGO 2)

The idea of recovery which they were introduced to succinctly articulated that which they already knew to be true (NGO 2; Practitioner 2; NGO 1):

"...the voluntary sector were very much involved as well who saw recovery as a very positive way of articulating what they had been saying for a very long time about the way they approach mental health issues." - (NGO 1)

Recovery became an accepted 'discourse' or, to use the words of Mary O'Hagan (2004) above, 'container' which represented the ideals which they wanted to express through their work.

While the term 'recovery' is mentioned in the Millan report, which reviewed the *Mental Health (Scotland) Act 1984* in 2001, it was used only in the traditional sense of the word, which is to recover from an acute illness (Millan 2001). It was not mentioned at all in the new *Mental Health (Care and Treatment) (Scotland) Act 2003*. Inclusion of recovery in the Act was discussed but it was decided that it should not be included because at the time recovery was not seen as a concept that could be applied to dementia and learning disabilities, which were also covered by the act (NGO 1).

4.5 The Scottish Recovery Network.

The Scottish Recovery Network, which evolved from the Scottish Recovery Forum, discussed above, became the main official vehicle for taking forth recovery work in Scotland.

Elsewhere we have spoken about the 'devolution effect' where the process and enthusiasm around devolution in 1999 opened up possibilities for the Scottish Executive to follow new directions in relation to mental health (Smith-Merry, Freeman and Sturdy, 2008; Smith-Merry, 2008). As a result of devolution Scotland's National Programme for Improving Mental Health and Wellbeing which was devised to drive work on population mental health was able to incorporate new ideas which may otherwise have been difficult to implement. The Scottish Recovery Network became part of the National Programme when it was launched in 2003.

Despite the Mental Health Division's early reticence around the concept of recovery by 2003 it had become one of the four aims for the Scottish Executive's new National Programme for Improving Mental Health and Wellbeing. The National Programme directed its action towards:

- "Raising awareness and promoting mental health and well-being
- Eliminating stigma and discrimination
- Preventing suicide
- Promoting and supporting recovery." - (Scottish Executive, 2003, p.2)

Crucially the National Programme was directed by Gregor Henderson, an individual who had been very open to early discussions on recovery in Scotland (Community 1; Community 2). This link was seen to be of key importance in explaining why recovery was taken up as an official policy priority for the Scottish Executive (Community 1; NGO 1; Community 2). Here a community activist, core amongst those in the recovery movement, was given a central role in the mental health division. This allowed the ideas that he brought with him to populate this new space – much as Mary O'Hagan's ideas on recovery had crossed over into the New Zealand government through her involvement in

the Mental Health Commission. Henderson's position validated the recovery concept and allowed for the production of new knowledge around recovery to be created through development of the Scottish Recovery Network and associated research grant opportunities.

It was in the first Action Plan developed by Henderson for the National Programme that the Scottish Recovery Network was 'officially' born. The action plan articulated the following role for a Scottish Recovery Network (SRN):

"To help promote and support the process of recovery for individuals and to gain a wider understanding and awareness of what helps people recover, the National Programme is supporting the development of a National Recovery Network for Scotland. The proposed aims of the Network are to collect and disseminate people's experiences of recovery and to provide information and advice to a range of local and national agencies to promote and support recovery. The proposed Network will also collect and disseminate relevant national and international evidence and material on recovery. More details will be provided as the plans for the Recovery Network develop." - (Scottish Executive, 2003, p.6)

Here the emphasis is on gathering evidence and sharing it. This process aimed to create a greater understanding of recovery, thereby working to answer the 'does it work?' question posed by the Mental Health Division back in 2000. One of those currently working within the SRN describes the work of the network in this way:

"[SRN is] a network in two senses. We are a network in that we are a pretty loose association of organisations and individuals so a lot people link in and work with us one way or another by coming to events and being involved in training to create a sort of a movement for a recovery approach. But also a network in terms of getting information out there as quickly as possible. About sharing information." - (NGO 1)

Much of the early work of SRN was not just in spreading the recovery message, but in actively bringing together and building the evidence for recovery. One of the first outputs of the SRN was a series of discussion papers on topics such as:

- 'Elements of recovery: International learning and the Scottish context' (Bradstreet, 2004).
- 'Recovery and community connections' (Connor, 2004).
- 'Researching recovery from mental health problems' (Berzins, 2004).

Much of this research has involved the bringing together of evidence which would effectively support what they were already advocating - to create a valid form of

knowledge which would support what was already known. Evidence building has also been an important facet of ongoing work by the SRN through projects such as the Scottish Recovery Indicator, peer support and the narrative research project (these are all discussed separately below).

The fact that SRN worked as an inclusive network to spread recovery rather than an official government committee which required the sector to learn about recovery was seen as important for spreading the word (NGO 1). Our respondents felt that while the recovery message would have spread to some extent without the SRN, it was important to have it as an official government policy:

“To be fair. The one thing that having that policy, that having that arm of a strategy on recovery coming from the government has meant that everybody has been able to hear that message and I think that was really important.”

- (Community 1)

Government endorsement through the funding of the SRN elevated the status of the concept and made more people receptive to the recovery idea.

4.6 Institutionalisation of recovery: policy documents.

Proceeding from the establishment of SRN a recovery focus was becoming established within several other areas of mental health in Scotland, including within the review of mental health nursing, *Rights, Relationships and Recovery*, and the policy for mental health services, *Delivering for Mental Health*, both of which were released in 2006 (NGO 1).

As the title of the document indicates the review of mental health nursing placed recovery as one of the key guiding principles for mental health nursing in Scotland. When defined it is articulated as one of the core ‘values’ underpinning practice in mental health nursing:

“Recovery. Promoting recovery and inspiring hope – building on people’s strengths and aspirations. Increasing capacity and capability to maximise choice.”

- (Scottish Executive, 2006b:14)

Like the definitions produced by our respondents the key aspects of this definition are choice and individual aspirations and goals. It is unclear exactly how recovery came to be included in the document, although the significant inclusion of service user voices within the consultation may be a reason. One respondent spoke about the strong consensus amongst those involved in the review that recovery as a concept represented a positive articulation of what they knew to be the right way to do mental health nursing (NGO 1). Other respondents spoke about the importance of key actors in both the government and

services ensuring that recovery was part of the nursing review (Practitioner 1; Community 2; NGO 2). Several specifically mentioned the work of Suzanne Forrest from NES who was involved in the review and conducted research on recovery at Napier University in Edinburgh (Practitioner 1; Community 2; NGO 2). Forrest had previously worked on the involvement of service users in nursing and had published several papers in the area (Forrest, Risk, Masters, Brown, 2001; Masters, Forrest, Harley, Hunter, Brown and Risk, 2004; Forrest, Brown and Risk, 1998). The reference group also included Simon Bradstreet who is Director of the SRN. It is interesting that despite its centrality within the document recovery was defined only once in the document, and even then only briefly – this perhaps representing that an understanding of the term was already well embedded within the mental health community at this time.

The document includes an 'action plan' which lists a range of action points and a timeline for action lists four specific actions centred on recovery principles:

“2. Mental health nurses will use recovery environmental audit tools to gauge their current practice and to inform development of recovery based approaches to care by the end of 2007.

3. A national framework for training in recovery-based practice to support the dissemination of recovery-focused frameworks into practice will be developed by the end of 2007.

4. Assessment and care planning frameworks and documentation should be reviewed and revised by the end of 2007 to ensure they reflect the models for mental health nursing practice described in the main review report ... maximising therapeutic contact time between mental health nurses and service users and supporting values and recovery-focused practice....

6. All acute inpatient units will adopt models of care described in the main review report... based on the principles of the Act and the recovery approach by the end of 2007. This should be actioned for all inpatient units by the end of 2008.”

- (Scottish Executive 2006b, pp.5-7)

The review was seen as an important way of imbedding a value, already held by many working in mental health nursing, within the structured practices and official ethos of their work (NGO 2; NGO 1). The targets contained within *Rights, Relationships and Recovery* were viewed as an important driver for making this happen within services (NGO 1). Action toward the targets was expected to be undertaken by the “Scottish Executive, NHS Education for Scotland (NES), NHS Quality Improvement Scotland (QIS), NHS Board Nurse Directors, Higher Education Institutions (HEIs), and mental health nurses themselves” (Scottish Executive 2007a). A national 'implementation group' was established to oversee the implementation of these targets with local implementation groups established in each health board (Scottish Executive, 2006c). A joint post between SRN and NHS Health Scotland was created to develop a national training

framework on recovery and work on implementing the nursing review (NGO 3; NHS Education Scotland, 2010). By 2010 action points 3 and 4 listed above had already been achieved and dropped. Actions 2 and 6 are still being worked upon and have been incorporated in some aspects into the targets contained within *Delivering for Mental Health* (Scottish Executive, 2006d; Scottish Government, 2010). It was important for the recovery targets to be within a major policy document like *Delivering for Mental Health* as it was feared that because it was such a strong message in *Rights, Relationships and Recovery* it might be seen as a “nurse-led or nurse-focused initiative” which might lead to ‘ambivalence’ amongst other professions (Practitioner 1).

The review continued the knowledge transfer between New Zealand and Scotland, which had been sustained through a series of visits and exchanges, many of which happened through the International Initiative of Mental Health Leadership (IIMHL) exchange programme (Government 1; NGO 3). One of the main sources of international knowledge drawn upon for the review came from New Zealand. The report states:

“Additional links were made with senior nurses in New Zealand, who generously shared information about progressing recovery focused practice in mental health nursing and services.” - (Scottish Executive, 2006a, p.9)

The report also draws on a review of mental health nursing in England which included a recovery focus.

The policy document *Delivering for Mental Health* was released in late 2006 and, like the National Programme and the review of mental health nursing, included recovery as a central guiding theme:

“We must ensure that we deliver on our commitments in respect of equality, social inclusion, recovery and rights.” - (Scottish Executive, 2006d)

The document included 12 commitments, the first of which was specifically centred on recovery (Scottish Executive, 2006d). This commitment referred to the development of a specific tool through which the principle of recovery and other associated values would be imbedded in the practice of mental health services. The resulting tool, the Scottish Recovery Indicator was piloted in 2007. This tool will be discussed in depth in the next section of the paper.

More recently recovery has been included in the latest iteration of the Scottish Government’s population mental health strategy *Towards a Mentally Flourishing Scotland (TAMFS)* and the consultation process and documents which led to its development. One respondent criticised the limited inclusion of recovery within the *TAMFS* document, but reflected that:

“Maybe its not a bad thing because you don’t want to be too closely aligned to the government anyway – you want to keep that little edge where people see it as being a bit different and actually want to buy into it rather than thinking they have to do it. That is one of the strengths of recovery. People actually want to do it.”

- (NGO 1)

Despite this the Scottish government was viewed as being very supportive of the development of recovery (NGO 1; NGO 2):

“[the government] aligned [recovery] with an organisational planning. They put the foundations in place for the rest of us to be able to work through.” - (NGO 2)

Most of our respondents were highly supportive of the movement of recovery into policy (NGO 2; Government 2; Practitioner 1; NGO 1). Having recovery as a policy focus was seen to place an emphasis on the issue that might not otherwise be maintained as key individuals left the system. As one respondent commented, “Yes it is. [Policy] is very helpful. Because some of those people who had the privilege before, some of them have moved on and people who take over their posts are then forced to be close to you” (NGO 2). However, the movement into policy was not universally seen as helpful. Ambivalence about the move of recovery into policy will be discussed in further depth later in the report.

4.7 Institutionalisation of recovery: the key technologies.

As reflected on in the discussion of definitions above, recovery can be conceived of as a set of core values and processes. These values and processes are manifest through various actions and technologies which target different parts of the mental health sector. As one government actor commented:

“So recovery. Tactically we are using it as a key way to get into the cultures and behaviours of the system...structurally the issues around respect and the quality of the interaction between the people receiving and the people offering the services is going to be the big thing....the first and biggest challenge that we have is to re-humanise services but recovery, because it is actually dealing with that territory, is a good way into it.”

- (Government 2)

The ‘values’ of recovery being used to reorient the system are implemented through a range of different technologies including ‘realising recovery training’, ‘values based practice’ training, a ‘narrative project’, the Scottish Recovery Indicator, peer support and Wellness Recovery Action Plans (Practitioner 2; Government 2; Practitioner 1; Community 1; NGO 1; Community 2; NGO 2). Here we reflect on the four main technologies: the narrative project, peer support, the Scottish Recovery Indicator and the Wellness Recovery Action Plans.

4.7.1 Narrative research.

A narrative research project was initiated by SRN in 2004 and involved collecting 'narratives' of recovery from 64 people across Scotland who had a lived experience of mental ill-health (Scottish Recovery Network, 2009a). The purpose was to:

- "Learn from the uniqueness of each individual's experience and identify common factors.
- Share stories to inspire hope and offer tools and techniques for recovery among service users, carers, friends and families, service providers and the wider community.
- Establish a Scottish evidence base of factors that help or hinder an individual's recovery from long-term mental health problems.
- Use the evidence to contribute to the development of policy and practice across all sectors, promoting a better understanding of what supports recovery and wellbeing.
- Guide and inform the work of the SRN." - (Brown and Kandirikirira, 2007)

As discussed earlier, there is a history of narrative work in relation to recovery including, most prominently, the narrative project undertaken by Hilary Lapsley and others in New Zealand (Bradstreet, 2006).

Our respondents spoke of the importance of the SRN's narrative project for developing understanding about recovery within a Scottish context (Government 1; Practitioner 1; Community 2; NGO 3):

"Narratives are an important evidence base." - (NGO 3)

"There was a strong focus about...what recovery means in Scotland and the narrative research project run by SRN helped to do this." - (Community 2)

Respondents spoke about the narrative project as working to 'Scottishise' recovery by ensuring that the values of recovery were reflecting what the community of service users understood recovery as. This 'Scottish version' of recovery was placed, as with the 'New Zealand version' derived through Lapsley's work, in opposition to an 'American version' of recovery which was viewed as being "more mono-cultural", less "community centred" and less flexible with regard to personal situations and needs (NGO 1; NGO 2; O'Hagan, 2004; Mental Health Commission, 2001). However, it is not clear that the American version did differ radically from the Scottish context (Community 2) or where this 'inflexible' American version was being enacted at this time. Indeed, many contemporary American definitions of recovery seemed to share much with recovery as understood in

the New Zealand and Scottish reports (Jacobsen and Curtis, 2000). One of our respondents attributed this situation to a process whereby the same influential, international texts, such as those by William Anthony or Patricia Deegan were continually circulated within a relatively small international community (Community 2). It may be that one of the central functions of the creation of the narrative reports was to help to strengthen the community working around recovery through creating a shared Scottish identity which was contrasted to an external, American, 'other'.

The narrative project served as a 'flagship' project which functioned to raise the profile of SRN, and recovery, amongst service users and practitioners (Practitioner 1). The narrative approach has also found its way into the practice of 'doing recovery' with service users. One psychiatrist we spoke to mentioned the way that service users were involved in writing "their own story" as part of their journey to recovery (Practitioner 2).

Individual narratives were brought together in a DVD and a book, 20,000 of which had been distributed by mid 2007 (NGO 3). The narratives were also analysed in order to assess the factors which had helped and hindered individual recovery (Brown and Kandirikirira, 2007). The findings were released as a report in 2007 and have served to provide a Scottish definition of recovery and an indicator of how work on recovery should progress. As the SRN writes, "This project has provided the foundation to all of our work" (Scottish Recovery Network, 2009a). An example of the utility of these findings has been in their application within the design of the Scottish Recovery Indicator (NGO 2).

4.7.2 The Scottish Recovery Indicator.

The Scottish Recovery Indicator (SRI) has been designed as a self-assessment tool measuring the extent to which services are implementing a recovery-oriented practice model within their work. It uses online form-based technology. Those completing the tool are led through it step by step and must answer questions relating to the extent of recovery practices within different aspects of their services. For example the practices relating to patient assessment are reflected on in order to ensure they take into account important aspects of an individual's "basic needs", which are listed as housing, nutrition, physical health, entitlements, personal care and spiritual care. Possible evidence of the service providing this is given, e.g.:

"Entitlements: Service assists with entitlements, advocacy and general advice e.g. legal, financial and housing. (Where indirectly provided, respondents should evidence knowledge of local agencies and offer examples of individual referrals.)

Personal care: Service provides help with personal care, as required. This could include personal hygiene, attention to clothing, haircuts, etc.

Spiritual care: Service records expression of religious or belief-based needs and enables access as required.” – (Scottish Recovery Network, 2010)

The following guidelines are given on the operation of the tool:

“There are three steps to completing the SRI

Step 1: Planning and preparation

- Ensure information is available
- Consider who will need to be involved
- Allocate tasks
- Determine timescales

Step 2: Collecting data

- Look for evidence in sampled assessment forms
- Look for evidence in sampled care plans
- Look for evidence in service information
- Interview service provider group
- Interview service user group
- Discuss strengths and issues raised

Step 3: Service development plan

- Consider indicator ratings
- Prioritise highlighted issues
- Determine timescales
- Allocate tasks
- What support might be needed

What you will need to use the SRI

To complete the SRI you will need:

- Agreement and commitment from your colleagues. To successfully use the tool you should have commitment from as many members of the team as possible.
- Access to, and permission to view, service user assessments and care plans as well as service information, policies and procedures.
- The capacity to arrange interviews with people providing services
- The capacity to arrange interviews with current or previous service users.
- At least 13 hours.” – (Scottish Recovery Network, 2010)

It is suggested that the tool should be completed with reference to the data contained in assessments, care plans and service information and through interviews with service providers and those who use the service (Scottish Recovery Network, 2010).

The tool’s creation was initially suggested as a result of the discussions around the implications of *Rights, Relationships and Recovery* and other discussions on “culture and behaviour” which were happening in early 2006 (Government 2; NGO 2). It was seen as

necessary to clarify what was important and possible in terms of recovery-oriented practice:

“At the time of the nursing review it was thought we were asking a lot of people to do things and people didn’t really know what they should be doing and what recovery practice in process was.” - (NGO 1)

These discussions led to the formalisation of plans for the creation of the tool as an aspect of *Delivering for Mental Health* which contained the following commitment:

Commitment 1: “We will develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights. The tool will be piloted in 2007 and be in general use by 2010.” - (Scottish Executive, 2006d)

In 2009 the implementation of the SRI was again committed to in the *Towards a Mentally Flourishing Scotland: Policy and Action Plan, 2009-2011* which guides work on population mental health in Scotland (Scottish Government, 2009).

The SRI tool was modelled on a US tool, the Recovery Oriented Practices Index (ROPI) which was developed by Anthony Mancini, an academic now working at Columbia University, for use within the New York State Office of Mental Health (Scottish Executive, 2007b). This tool was identified as an appropriate base from which those in the SRN could work toward the development of a Scottish indicator (Government 2). However, in order to make the tool effective in the Scottish context it had to go through a process of ‘Scottishisation’ (Community 2; NGO 1). This involved adapting the tool with language and practices appropriate to Scotland (NGO 1; NGO 2). Part of this process involved making the tool much more centred around process and self-assessment, rather than external evaluation:

“The ROPI was much more stick than it was carrot...It was an external evaluation and that is the antithesis of recovery for us in Scotland. So it might be that in America you can go and say to a service this is what you are doing wrong and this is what you are doing right but we have a different interpretation of recovery. Recovery is ‘you are doing the right thing for you at the right time.’” - (NGO 2)

As this quotation demonstrates, self-assessment - as opposed to external audit - was viewed as a Scottish value (Community 2). The definition of what recovery meant in a Scottish context came from the narrative research project (NGO 2). A development group met and went through the tool in order to ensure that its language - they “sat rephrasing sentences” - and content were appropriate (NGO 1). The tool was also tested within several pilot sites to make sure it worked within the Scottish context and further changes were made.

The 'formalisation' of recovery goals within service provision which the tool represented was seen as important. As one respondent reflected it:

"...took the discussion away from it being a nice cosy service user discussion about 'isn't recovery a nice thing' into something we wanted to directly apply to how we were doing services..." - (Government 2)

The tool aided in the 'journey' being undertaken by services moving towards a recovery consciousness. Through being obliged to undertake the SRI self-assessment exercise it was argued that services would reconceptualise their service provision through a recovery lens and be able to more effectively implement the recovery model (Practitioner 2; NGO 2; Practitioner 1). One respondent reflected on this process:

"What we have found in tests and now is that the conversation is everything. So you have a team of people doing it...and having a conversation about it and saying 'well the implications for us are we never talk about strengths.' 'We are an acute admissions ward, why would we want to talk about strengths? They are ill.' 'Well actually when you talk about strengths people talk about what they can do and that creates hope.' 'Oh right. Ok. That's an interesting concept, I hadn't thought of that before'" - (NGO 1)

Another respondent viewed the self-assessment aspect of the tool as appropriate because it allowed recovery to grow organically – a process that could not be rushed – to become 'owned' by services and integrated thoroughly into practice (Practitioner 2). More important here than the data produced through the use of the tool was the process of it being used. The use of the SRI technology drew attention to recovery in services in a way that would not otherwise be possible.

Importantly for our respondents the data produced through the use of the SRI was not 'assessed' by anyone but the service who was entering the data (NGO 1; NGO 2). For individual services the data from the SRI was seen as important as it served to provide "evidence" about the extent of recovery practices within the organisation. They could then work from a baseline to improve their performance against each part of the indicator (Practitioner 1). It also served to demonstrate that recovery work was indeed being done and was not just a vague concept to which lip service was being paid: "...the recovery indicator tool has shown us that there is a lot of recovery oriented work going on but it is really hard to evidence it because paperwork and the way we document things doesn't reflect that." (Practitioner 1; Practitioner 2).

4.7.3 Wellness Recovery Action Planning.

Wellness Recovery Action Planning (called WRAP for short) is another tool imported from America into Scotland and mentioned by our respondents as a significant part of the

'doing' of recovery by services in Scotland (Practitioner 1; Community 1; NGO 1; NGO 2). Devised by Mary Ellen Copeland, herself a service user whose work on recovery developed out of her own search for personal recovery, WRAP is "...used to help people who experience mental health problems better manage their wellbeing and recovery. It is a simple tool that can help people take more control of their recovery, plan how to maintain wellness and reduce, and better manage, periods of illness." (Scottish Recovery Network, 2009b). Copeland, who developed the programme, runs a large non-profit organisation, the Copeland Centre for Wellness and Recovery and has registered and trademarked the WRAP programme which is shown in the following way on the organisation's website: "WRAP® stands for Wellness Recovery Action Plan™" (Copeland Centre for Wellness and Recovery, 2010). The significance of this is that only facilitators who undertake official training can offer WRAP training themselves and there is only one advanced level trainer in Scotland that can train (NGO 2; Scottish Recovery Network, 2009c).

Similar to the emphasis on self-assessment within the SRI this tool is designed as a 'self-management tool'. The SRN describes a WRAP in the following way:

"WRAP is underpinned by a number of core principles:

- That recovery is possible ('hope')
- That individuals should take personal responsibility for their own lives and well being ('personal responsibility')
- That it is important to know yourself, to be self aware ('education')
- That it is important to believe in and advocate for oneself ('self advocacy'); and that the support of others is vital ('support').

People work within these principles to create their own WRAP. Each plan should include the following components:

- Wellness toolbox
- Daily maintenance plan
- Identification of triggers and associated action plan
- Identification of early warning signs and associated action plan
- Identification of signs that things are breaking down and associated action plan
- Crisis planning
- Post crisis planning
- Creating a WRAP can be a challenging process and the process is best supported by a trained facilitator in a group setting." - (Scottish Recovery Network 2009d)

As this list demonstrates the emphasis is on an individual's understanding of their own life:

"[WRAP] is about how you live your life. All these things are different tools that should be used and the more we use them the more we will see recovery. I think the consumers themselves are the biggest inspiration in it because as they recover other people want a bit of that. Other people want to go on their own journey and recover also."
- (Community 1)

The tool is not assessed and individuals may "journey" towards recovery through WRAP at their own pace (Community 1). WRAP is administered by a facilitator either on a one-to-one basis or within a group setting in services or self-help groups (Scottish Recovery Network, 2009d). While it was service users themselves who were originally meant to act as facilitators, in Scotland staff in services are also now trained to take up this role (Practitioner 1). In services it needs to be carefully implemented within a recovery orientation or, it was feared by one respondent, WRAP would become just another care plan (NGO 2)

4.7.4 Peer support.

A Support Worker Pilot programme was undertaken in 2008-2009 by the Scottish Government and SRN to pilot the paid employment of peer support workers within mental health services. The potential to develop the pilot was first mooted in papers by SRN director Simon Bradstreet in 2005 (Bradstreet, 2005; 2006). In 2005 there had been a visit to Scotland by Gene Johnson, a peer support trainer from Arizona. Scottish-based training on peer support followed which aimed to answer the questions: 'what can we learn about peer support to enable Scotland to do it itself?' and 'how can we get people to understand peer support enough to do it?' (NGO 1). Peer support was also discussed in exchanges related to the IIMHL conference in New Zealand in 2005 (Community 2). This was followed in 2006 by a literature review and a national conference on peer support. The idea was then taken up in 2007 within *Delivering for Mental Health*, which made a commitment to the development of a peer support pilot project (Scottish Executive, 2006d).

Service user groups in different parts of the country, such as the Highland User Group, Acumen, Augment and the Hearing Voices Network have been involved in implementing peer support work (Community 2; NGO 2):

"They now employ acute inpatient forum workers who are peer support workers and that has shifted things around a little. A user organisation is now placing peer support workers in acute units so they can assess patient experience and it has very much come from a local recovery network."
- (NGO 1)

As this quotation shows, peer support workers were seen to challenge the traditional hierarchies within mental health services and act as a disrupting force which could

change the culture of mental health service delivery (NGO 1). This disruption helped services to move towards a recovery approach.

The peer support pilot project was seen as helpful in the way it helped to reorient the services toward recovery “values” (Practitioner 1; Mclean, Biggs, Whitehead, Pratt, Maxwell, 2009). On reflecting on the pilot in their own health board area one respondent commented: “...the peer support pilot...was hugely beneficial in the areas that the peer support workers were working in looking at things like the language and the ethos of recovery” (Practitioner 1). In the review it was noted that, while the peer support workers were viewed as moving the service toward a recovery orientation, their work was made more difficult where this was not already the case. The burden that this placed on service users to have to pull a system into shape was seen as problematic (McClellan et al., 2009). Indeed, many of the problems related to the ‘system’ being not yet in the right place to adequately cope with having this new type of role working within a ‘traditional’ domain.

4.8 Resistance, ambivalence and recovering from recovery.

“So I think there is a growing acceptance that it is there, but I think there are pockets of, not resistance, but ambivalence.” - (Practitioner 1)

Not all involved in mental health in Scotland have been completely supportive of the movement of recovery into policy. Some have been resistant to its development and others have been fearful that the institutionalisation of recovery within these tools has meant the colonisation of a once service user-led recovery movement by the bureaucratic world of policy which operates with very different rationale and tools (Practitioner 2; NGO 2; Community 2; NGO 1; Community 1; Practitioner 1).

All of our respondents however were in favour of the movement of recovery into policy and few could point to significant areas of resistance to recovery as a policy priority. As one respondent commented, “It is a difficult thing to argue against” (NGO 2). This, however, could be a problem in itself:

“There has been a criticism of the work... It is impossible to disagree with so as soon as you do argue with it you are seen as some sort of evil anti-helping people type person when you are actually trying to make a cogent point. It’s almost too PC to disagree with and I don’t think that is helpful.” - (NGO 1)

Psychiatry as a profession was singled out by several respondents when asked where resistance to recovery might lie (Practitioner 2; NGO 2; Community 2; NGO 1; Community 1). The reason for this resistance was seen to lie in a lack of understanding about recovery, rather than a real resistance to the values that recovery represented (Practitioner 2; Community 2; Government 2). However, it was felt that it would be

wrong to criticise psychiatry because this would not fit into an “ethos” of recovery as a process (NGO 2). Psychiatrists were on a journey, but they were coming from a very strict understanding of practitioner-patient relationships which recovery as a concept disrupted, and so their recovery journey would take longer (NGO 2; Practitioner 2):

“So it’s also difficult for psychiatrists and we have to recognise that instead of blaming – blaming will get us nowhere. The whole ethos of recovery is about reconnecting and being alive in some way, about getting back to your species rather than about me having a go and labelling in some way. We seem to be objectifying psychiatrists...[and] reducing [them] to a role and a label which is psychiatry and what we are trying to do in recovery is to get away from that... Psychiatry is involved, but they are just not at the forefront of it. They are not at meetings shouting about it but they are trying to work out how to get involved, but its difficult for them.” - (NGO 2)

Psychiatrists were viewed as moving slowly towards a recovery-oriented practice with different parts of psychiatry moving at different paces (NGO 1; Practitioner 2; NGO 2; Community 1). This process could, however, be halted by organisational and legislative constraints related to their practice which made them treat in certain ways and offer drug-based treatment even if their patient said that it would not help their recovery. One respondent argued that psychiatrists were under a legal obligation to act in a certain way because “...no matter how you cut it the bottom line is that if anything happens the psychiatrist is normally the person that is pulled in front of the coroner” who would question the psychiatrist as to why drug-based interventions were not used (Community 1).

Some respondents expressed concern that the agenda had become too close to government and had lost its connection to both the service user movement and the movement within professional groups like nursing (Community 2; NGO 1; NGO 2; Community 1). It had started as a “grassroots” movement, but local areas had begun to feel distant from the process with the agenda now being “...driven by the centre rather than local groups” (Community 1). There was a fear that individuals would feel pressured into implementing recovery and that resistance would arise from this:

“[the SRI] really came from nurses, but kind of gets detached to become the commitment, but it was the nurses who said, ‘well we know something about recovery, but we want to know how we are doing it.’ Then that becomes adopted by government. But that’s the role of government, to listen to what people are saying and then when they adopt it we look at it differently and say, ‘government are telling us to do that’ but that’s not true.” - (NGO 2)

Individuals and practitioners needed to be free to take on recovery in order to fully implement it in their work and their lives. It needed to be an organic process, but it was

feared that such a process could not freely happen within the current system. This was reflected in the comments of several respondents, who were concerned at how the 'system' had transformed recovery:

"People do their recovery and people had been recovering before all this came on board so who owns it? Is it grounded in users' experiences, in people's experiences of recovery or is it something that comes down as a policy and mediated through professions. That's an important point." - (Community 2)

"One of the big tensions, I think in some ways, is that this has been professionalised, that recovery has been professionalised and the professionals have taken responsibility for it and rolled it out." - (Practitioner 1)

The bureaucratisation of recovery through a tool like the SRI was a concern for respondents who had been service-users:

"Indicators are useful and I think [the SRN have] done a brilliant job on that but I think we have become too bureaucratised in recovery now." - (Community 1)

It was also feared that in the wrong circumstances the SRI could become the audit tool which those designing the tool had been so keen to avoid (Community 2; Government 2):

"It should be a system for people to improve and change services rather than scoring and condemning them. That's why it is a change heuristic model rather than a performance management heuristic model." - (Government 2)

The tool had to be 'left open enough' to allow for it to be used appropriately in different settings (Community 2).

As discussed above, WRAP was originally formulated so that it was service users themselves who should act as facilitators but now staff were also taking up this role. One service user commented that this represented "further evidence of the colonisation of a process" (Community 1). Another respondent, warned that a problem with current practices relating to WRAP was that it was being instituted "in a traditional way in a traditional environment" (NGO 1). WRAP could only be successfully implemented within a service setting which had already gone through the journey of becoming 'recovery oriented'. Concern was also raised about the over-reliance on WRAP as the sole tool for this type of intervention: "WRAP is *one* tool and yet it is being used across the country as if it is *the* tool." (Community 1).

One respondent commented at length that the 'system' has to meld recovery into something that it was never meant to be in order for work to be done within this context:

"In terms of Scotland [recovery] needed to [become a policy goal] to work and I think unfortunately along with that comes this desire, because policy makers are always looking for models, and because recovery has never been a model for us it has always been a process, I think this desire to find a model I think some of us became quite antagonistic towards, you know that there was a model that you could fit everybody and that would do recovery and that's never been the experience of recovery from a consumer perspective, but it's what systems like. Systems like models because you can measure them and work with them in a much easier way." - (Community 1)

Another concern related by respondents was scepticism about the extent to which recovery was genuinely being implemented within services (Practitioner 2; Community 1; NGO 1). It was thought that some services may use the term 'recovery' but not actually implement recovery oriented practices: "They use it to rename wards. But I say to them, 'recovery is a verb, not a noun'" (Practitioner 2). There was also a fear encountered by two respondents that the idea of recovery was being used as a way to cut services and shift responsibility for mental health back onto the individual (Community 2; Community 1).

Despite concerns raised by respondents several felt that recovery had to become a part of policy and because of this the "angry edge"- those pushing for more radical action around mental health - could move on to more progressive work (NGO 2; Community 1; NGO 1; Government 3). Two respondents reflected on this process at length:

"I think that's a normal part of the process. I don't think it's strange that it happens, and I think every time it happens the system moves forward but I think in order to keep the system moving forward people have then to refine things and change things again. So...the reality is that we are now beginning to think beyond recovery and you'll start to see conferences begin to happen now that are called 'beyond recovery' and things like that and a lot of that is a consumer response to what we see as the start of the next turn off on the journey." - (Community 1)

"It's the next step with recovery because I think that what recovery does is it treats you as a whole person and it says there are all of these aspects you can move forward with and the big thing I think recovery is starting to do - and I think the recovery network has been very successful in getting its message across - is it's imbedded itself in services where I think people are starting to think of themselves in a recovery model and I think there is a cultural shift coming. So I think we are almost a bit ahead of the wave from the cultural shift and saying 'oh good now when you've got there we want you to go a bit further in this'." - (Government 3)

This “angry edge” was the same service user and activist community – meeting and talking outside of government and services – who had been so instrumental in raising the profile of recovery to the level that it could be picked up within policy in the first instance.

5. Discussion:

“So [the Scottish Government] have invested a lot of credit, given [recovery] a lot of value really when you think about what recovery is and where it has come from – it’s really a social movement to some extent and the government have been very heavily involved in supporting that. It’s quite radical really. Some of the other countries look at that and say ‘wow, it’s quite a brave step’.” - (NGO 1)

“Recovery is both a vision for the future and a social movement that seeks to bring about change in how we think about mental health problems, how we live with those experiences and how we support people whose lives are affected by mental health problems.”

- (Gregor Henderson cited in Scottish Development Centre for Mental Health, 2002)

The recovery story, as told by members of the mental health community in Scotland, describes a process by which a concept, originally championed most strongly by service users, has moved into policy. In bringing together the history of recovery as told by our respondents recovery has been constructed as a ‘universal’ concept, identified and put into practice by key groups over the past 50 years, including through the psychiatric rehabilitation and AA movements. Developing organically, discussions around recovery within service user movements and the actions of key service users such as Mary O’Hagan in New Zealand and Ron Coleman in Scotland helped recovery to be recognised as an important concept. What is common to all of these key individuals and groups involved in developing the concept until the mid 1990s were all outside of the ‘mainstream’ mental health establishment. From this time however, through a series of key steps and processes recovery gradually became part of the mainstream to the extent that it has now become a guiding value for many mental health policy regimes across the world. This research has allowed us to see how this process from social movement to government policy has been accomplished in the case of Scotland.

As the quotations with which we opened this discussion section so clearly indicate, it is useful to think about this case study in terms of social movements. A significant number of our respondents used the word ‘movement’ in their interviews to refer to the development of recovery (Government 1; Community 1; Community 2; NGO 1; Practitioner 1; NGO 2; Practitioner 2). Recovery is also described as a ‘movement’ within Scottish Government literature on recovery with, for example, the SRN’s major 2007

report on its narrative research project referring to the “recovery movement” on multiple occasions (Brown and Kandirikirira, 2007).

5.1 Social movement theory.

Social movement theory, specifically David Snow and Robert Benford’s theories of framing, are useful in thinking about processes around the development of social movements (Benford and Snow, 2000; Snow, Rochford, Worden and Benford, 1986; Snow and Benford, 1988). Borrowing from Goffman’s (1974) conception of frames as “schemata of interpretation”, within social movement theory ‘framing’ refers to the process whereby a social movement becomes united around a particular conception of an issue (Snow and Benford, 1988). Benford and Snow (2000, p.614) describe the action of frames in the following way:

“Frames help to render events or occurrences meaningful and thereby function to organize experience and guide action. Collective action frames also perform this interpretive function by simplifying and condensing aspects of the ‘world out there’ but in ways that are ‘intended to mobilize potential adherents and constituents, to garner bystander support, and to demobilize antagonists’.”

Critically, a particular frame will also denote a specific way of acting on an issue in order to achieve a desired set of effects. A frame thus encompasses a way of both speaking about and acting upon an issue. For example, if mental health were conceptualised within a bio-medical frame it would be spoken about using a bio-medical discourse and acted upon through drug regimes or other medical technologies valid within this frame. Frames are in a constant process of flux as they challenge and are challenged by alternative framings of the issue. They are thus active, contested and changeable and Snow and Benford (2005, p.206) write that frames and framing should be thought of as a verb rather than a noun in order to accent the dynamism of the processes.

Snow and Benford (1988) break framing up into a series of different processes which they describe as “core tasks”:

Diagnostic framing - the identification of a shared problem which needs to be acted upon.

Prognostic framing - the development of a common understanding of how this problem should be addressed.

Motivational framing - provides a reason for why the issue should be acted upon now. Motivational frames thus “function as prods to action” (Snow and Benford, 1988: 202). For example, in recounting research on the nuclear disarmament movement Benford and Snow (2000: 617) comment that motivation was enforced

through “socially constructed vocabularies [which] provided adherents with compelling accounts for engaging in collective action and for sustaining their participation.”

These core framing tasks are very clear when we examine the story of recovery in Scotland that we have presented here. Each of the “core tasks” of framing can be identified within our case study:

Recovery and Diagnostic framing.

The shared ‘problem’ that the movement defines itself in relation to is a mental health system that serves to compound an individual’s suffering through attitudes and work practices. As the definitions with which we started our report describe, the recovery movement is defined around a set of strong values which are characterised by an emphasis on individuality, choice and the validity of personal journeying. In identifying its core values the recovery movement sets itself up in relation to a system and way of acting that is the antithesis of these values: a system and way of behaving that is impersonal and highly oppressive to those experiencing mental ill-health. This strengthens the core values of the social movement. Benford and Snow (2000:615) characterise this process, which identifies ‘victims’ and ‘oppressors’, as ‘injustice framing’ and locate it as a classic type of diagnostic framing. The narrative projects embarked upon in both Scotland and New Zealand serve as a diagnostic script which emphasises this injustice framing.

Recovery and Prognostic framing.

‘Recovery’ as a value put into practice through personal interactions and systemic behaviours is the answer to how this problem should be addressed. Within the recovery movement in Scotland there has developed a common understanding of how the problem should be addressed, namely through a process whereby those experiencing mental ill health and those working in services to address mental ill-health understand that recovery is possible and put in place steps that will lead to it. This process amounts to a reconceptualisation of the identity of the service user and of service practitioners in relation to this identity. This is done through the use of a range of key technologies (discussed in section on ‘diffusion’ below) which are fashioned for use with different actors. The SRN’s narrative research project was also a key tool for the development of this core framing task as it served to strengthen the definition of recovery within a Scottish context and to highlight particular ways that the mental health system could be acted upon in order to orient itself toward recovery.

Recovery and Motivational framing.

The base argument which forms the motivation to act on recovery is that individuals experiencing mental ill-health were not living fulfilling lives and that the mental health

system was compounding this. This meant that individuals would receive a diagnosis, enter into a mental health facility or other treatment regime and either not improve or quickly relapse. They lived without hope and this led to poorer outcomes from treatment and higher levels of medication use and suicide. The narrative research project was again an important tool for asserting this motivational frame as these narratives clearly demonstrate the significant problems faced by individuals before they encountered recovery.

An example: Would Recovery Work in Scotland?

Particular documents, such as that summarising a 2002 workshop on recovery in Dundee which considered how recovery should work within a Scottish context, clearly articulate the strategic way the movement around the recovery frame was built. This document, *Would Recovery Work in Scotland?*, derived from a one-day national dialogue event which was a key founding event for the development of the SRN. The event included in the audience “35 people attending as individuals, 34 from statutory agencies, 35 from voluntary organisations”. It defines the problem as a lack of ‘hope’ and ‘control’ for which recovery is the antidote as it enables “...individuals to take charge of their own lives with the support which they require. It is about empowering people to make real choices for themselves” (Scottish Development Centre for Mental Health, 2002: 3). This definition is a prognostic framing tool, as is the list of how recovery should be worked upon:

- “support the development of services and interventions that are recovery focused
- nurture the development of recovery focused workers
- nurture the process of recovery for people with experience of mental health problems” - (Scottish Development Centre for Mental Health, 2002: 4)

Motivation for acting is given through the inclusion of personal stories of individuals who had suffered from practices within services which were not recovery focused:

“Audrey described her experiences of being diagnosed and treated and the effects that her medication had on her ability to work and to study. She came to feel that she no longer wanted to live under the shadow of medication. She felt she had been ‘written off’ and was depressed – ‘who wouldn’t be?’”

- (Scottish Development Centre for Mental Health, 2002: 5)

In this document we find the core tasks already well defined in terms of how they would be eventually put into practice. The main task from this point was thus to build the movement through enforcing the message for those who already understand it and to diffuse the concepts into a new audience. The document outlines the “ways ahead” for “people already committed to recovery” and “for others who have yet to ‘get the message’ of recovery” (Scottish Development Centre for Mental Health, 2002: 12). This process of diffusion was key to building the movement.

Diffusion:

Benford and Snow (2000) identify particular processes which typically work to achieve these core framing tasks, including the multiple processes of frame alignment through which the goals of one social movement garners increasing consensus and attracts new adherents. One particular aspect of frame alignment which is particularly pertinent to this case study is the process of 'frame diffusion' (Benford and Snow, 2000, p.627). Frame diffusion has been applied to a consideration of the way that a particular frame is transmitted from one social movement to another or from one culture to another (Benford and Snow, 2000, p.627).

In this context we examine the way recovery has moved from the service user and activist community into policy. Through diffusion "ideas, items, or practices...are framed so as to enhance the prospect of their resonance with the host or target culture: strategic selection or adaptation and strategic fitting or accommodation." (Benford and Snow, 2000, p.627). Actors involved in frame diffusion engage in processes of "strategic selection" and "strategic fitting" in which "the transmitter [is] actively engaged in tailoring and fitting the objects or practices of diffusion to the host culture." (Benford and Snow, 2000, p.627). Once it gained a foothold within the policy framework the recovery movement promoted particular technologies which have aimed to diffuse recovery by consolidating support and bring new supporters to the movement. The technologies used to diffuse the recovery model within Scotland are holistic and happen at both a personal and public level. The Government has developed a range of different technologies in order to target different actors in order to foster greater understanding and use of recovery principles which will also serve to strengthen the recovery movement. This can be seen in the development of the SRI, WRAP training, Peer Support, each of which act on the mental health system in different ways. For example, the SRI targets those working in services. Through the process of using the SRI – and particularly the conversations they have and the tasks they must go through in order to fill in the tool - service providers come to reconceptualise their work in terms of how it relates to a recovery model.

The personal journey:

One process which many of our respondents referred to in one way or another within the interviews as being central to the doing of recovery was the 'journey' which individuals and organisations must go on in order to be fully 'oriented' towards recovery principles/values. These quotes clearly demonstrate this concept:

"it's a shift in culture to becoming far less blaming because that's very easy to get into when you see people as illnesses." - (Practitioner 2)

"[they] have twigged that mental health is for everyone. People who deliver mental health services don't have an immunity to having stresses and problems...."

When I'm doing training I share some of my own experiences of stress and mental health and mental distress.... [but] culturally that's not to date what we have been encouraged to do. Staff haven't been trained to share experiences. Staff have been trained in a way that they are the experts, that they have all this clinical expertise and 'we are there to help you, we can fix you, we can make you better.' It's a big challenge..." - (Practitioner 1)

"It is clear to me that there are a lot of practitioners who see recovery as what they came into psychiatry to do. That this is their reason and a lot of practitioners get almost a second lease of life out of these ideas around recovery and in fact you could argue - I would argue - that they themselves have recovered because of it." - (Community 1)

"It entails a refocusing of what we do. Using it as a starting point for anything you do for people with mental health problems... This leads to fundamental changes, real transformational stuff." - (NGO 1)

"...it's imbedded itself in services where I think people are starting to think of themselves in a recovery model and I think there is a cultural shift coming." - (Government 3)

As these quotes demonstrate the 'doing' of recovery is conceptualised as something that needs to happen at a very fundamental level and necessitates a change in ways of thinking which will then lead to new ways of acting. It is the process of using the key technologies of recovery which lead to this reconceptualisation of self. This message is transmitted by the key recovery tools, which speak to different audiences in ways which are meaningful for them and allow them to embark on the recovery journey.

5.2 Structural factors.

Respondents highlighted the way certain 'structural' factors facilitated the uptake of recovery within a Scottish context. Benford and Snow (2000, p.628) write about "political opportunity structures" as conditions which might make a particular framing of an issue more likely to succeed. In our case study there are two main factors which facilitate the movement of recovery into policy. The first is the circumstances around devolution and the second is the opportunity posed by the situation of particular key actors within the official structures of policy making.

As discussed in previous papers, devolution offered the opportunity for those in the mental health community in Scotland to suggest new policy directions to the government. In response to the situation before devolution in which Scots felt cut off from decision making in London, the new Scottish Executive attempted to develop an 'open' government which has been characterised by consultation and public participation.

This open approach to government was viewed as an opportunity by those in the mental health community who wanted to see a new direction for mental health in Scotland ('see me', 2006; Smith-Merry, 2008). In order to set itself apart from England the Scottish government also set out to make a name for itself in mental health on the international stage through innovative programmes for public mental health (Smith-Merry, Freeman and Sturdy, forthcoming). These factors allowed new ideas – like recovery - to emerge, enter policy and then be prioritised by the government.

Throughout our interviews respondents spoke about the work of key actors who were in the right place at the right time. Respondents highlighted the role of the service user Mary O'Hagan in her position within the New Zealand Mental Health Commission as being key to recovery being included in their *Blueprint* document (Government 1; Community 2). The inclusion of service users in the work of the Commission was seen as down to the leadership of Barbara Disley who was the first chair of the Commission (Government 1; Community 2).

In Scotland key actors were service users such as Ron Coleman whose accounts of their own recovery were widely discussed at events hosted by the voluntary sector (NGO 2). The meeting together at the Dundee Visions and Voices Conference of key actors dotted throughout the system was a critical event in the Scottish recovery story. This group, from which germinated the Scottish Recovery Network, included Simon Bradstreet, then at SAMH who went on to lead the network, and, most significantly, Gregor Henderson then working with the SDC who went on to direct the Scottish Government's National Programme for Improving Mental Health and Wellbeing. Gregor's movement from community actor to government actor was seen to facilitate the move of recovery from social movement to government. Gregor was able to take the community interest and his knowledge of the institutionalisation of recovery in other contexts and use his position in the government to validate this knowledge and institutionalise it within Scottish government policy documents (Practitioner 1; NGO 2; Community 1). As one respondent commented, those like Gregor who found themselves in privileged positions "married their gut instincts and made them aligned with an organisational planning. They put the foundations in place for the rest of us to be able to work through" (NGO 2). Once it started to move into services then key champions in different professions such as psychiatry started to take it on and spread the word through their networks (NGO 1; Practitioner 1).

6. Further thoughts and questions to explore.

This report has tried to 'tell the story' of recovery in Scotland. In a way it is a kind of history, though we have necessarily concentrated on things that were of academic interest to us and the wider project of which we are a part. It is not a complete history, if there could ever be such a thing.

It inevitably looks backward: it tries to make sense of where we are by understanding where we came from and how we got here. Researchers and policy makers - perhaps all of us - are always driving in the rear-view mirror, as Marshall McLuhan put it. But what might we say about the future of recovery - and of those to whom it matters - on the basis of what we have written here?

We think it is not for us to make predictions, let alone to give recommendations or prescriptions. To that extent, we have tried to research recovery in the spirit of recovery itself: just as it is for those affected by mental illness - whether as service users, practitioners, policy makers or others - to work out what recovery means to them, so it is for you to draw on our work as you see fit.

But we do accept that we should play a part in identifying and discussing 'emerging issues' in recovery, rather in the way a peer support worker might. We have learned a lot from you, though it has often been more like learning *with* you as we have gone back over the way things have developed. What we really have to say has already been said, in the body of this report, but we still want to give back what we can. We would like to continue the conversations we began with you in interviews, on the phone, by email, in feedback sessions and casual encounters at other meetings. What follows here are no more than prompts - invitations, perhaps - to further discussion: they have to do with knowledge, learning, politics, policy and trajectory. The following paragraphs reflect in general on our research in relation to the feedback we have received. A list of specific points raised as part of the feedback process which has already taken place is included in Appendix 1, which follows.

Knowledge: Our initial research interest was in the relationship between knowledge and policy: in the different ways different kinds of knowledge are used in policy making, and in the ways policy makers themselves create knowledge about what they do. We were interested in recovery as a new way of thinking about mental health and illness and in the way this new understanding seemed to have entered and established itself in the policy domain. We have been struck by the way in which taking recovery seriously has meant reassessing the knowledge claims of a range of actors, promoting what people who are services users themselves know about what they need and relativising what is often taken to be the more authoritative knowledge of researchers, professionals and policy makers. In many ways, recovery seems to inculcate a kind of self-knowledge: a new awareness of capacity and autonomy on the part of service users, for example, and a new reflection on the part of service providers about what they offer. Measuring tools such as checklists and indicators seem to play a key part in the production of this self-knowledge, though they also begin to prescribe the form it should take. Meanwhile, debates about the real meaning of recovery continue: often, it seems that the development of recovery is contained in successive attempts to articulate what it should mean. In this way, the development of knowledge about recovery seems to be

coterminous with the development of the language in which it is expressed and debated; producing a definition of it seems to be a way of producing the thing itself. Who knows what recovery is?

Learning: The idea of recovery originated outside Scotland, and much work has been done to make it look and sound and feel Scottish. This is consistent with the idea that it is for those in recovery to know what they mean by it, and one of the reasons that definitions of it are so elusive. Both service users and policy makers in Scotland have learned of and about recovery from counterparts in other countries; that has been made possible by both informal and formal networks, such as the International Initiative for Mental Health Leadership. In the same vein, one of our respondents remarked that the rise of recovery has more or less exactly matched the rise of the internet, and the ready international communication that has made possible. Now, Scotland's recognized work in recovery makes it a 'must-see' for visitors from abroad. Interestingly, Scotland is seen as worth learning from because it has itself a developed capacity to learn. In this sense, it is both beacon and searchlight. The continued vitality of recovery in Scotland may depend on keeping this learning-and-learned-from characteristic in balance. What do we have to tell others about recovery, and what do we have to learn from whom?

Politics: Successful ideas bring communities of interest together; in a way, they create a community where none existed before. To the extent that the idea of recovery 'invites agreement' it hides its politics. But when arguments about meaning break out they are often between people with different purposes. The good idea that is recovery is not good to everybody in the same way. Recovery can be a source of liberation, for example, but it can also be commodified and packaged and sold as training or therapy. Likewise it can be used both to preserve the independence and autonomy of those affected by mental illness, but can also be used to legitimise cuts in services, and it can be both a source of inspiration and reduced to a set of indicators. It can be a very personal, highly individual process and also a collective experience. That there should be different uses, interpretations and applications of the idea of recovery seems good and right (and consistent with its spirit). By the same token, however, it is essential that these different uses be recognised and debated. As the recovery community extends beyond its original core of advocates and activists, where and how will it do that?

Policy: To many of those we talked to, it seemed right that recovery should be adopted as policy. That gave it new status and authority, but also seemed to prescribe some kinds of action to be undertaken in its name - and not others. The enduring problem for recovery as policy is that it must fit - or be made to fit - with and among other policies. It seems to conflict, for example, with the promotion of Integrated Care Pathways (ICPs), which are based on specific diagnoses, while recovery focused practice would base a person's care on their own particular needs rather than their diagnosis. Meanwhile, though recovery made a big impact among nurses it made almost none among GPs: this

is a big gap in the system and an area of silence in our report. Does recovery fit with other aspects of health policy? Should it? If so, might it be used as a source of change in areas other than mental health? Is it really a policy or a provocation?

Trajectory: Recovery is an idea whose time has come, or may yet come, or is already past. We have a sense of ideas such as these having a natural trajectory, of emerging somewhere, of being taken up and used - often being reinterpreted along the way. This reinterpretation or translation of ideas is an ordinary and necessary part of the process of relevant communities learning what they are and taking ownership of them. Over time, however, a single concept can become invested with more meaning than it can bear and other more specific ideas emerge to take its place, galvanising new groups in different ways. So we might think of recovery as simply the next step on the ladder rather than the end point of our thought and action. And that begs the question as to what should come next.

Appendix 1: Feedback.

We provide here further thoughts and questions that have arisen from this research. We include both our own reflections on the research and those that have arisen from feedback that has been given on the draft report which we distributed to all participants. We also held a feedback event and collected responses at that event. These are thoughts and questions that should be considered in relation to recovery work in Scotland, but where we don't have the data from our interviews or documentary analysis to explore them further at this time.

- Policy itself is not a bad thing, but its lack of connectedness is. It lacks an ability to deal with the human dimension (which needs to be at the forefront of work on recovery).
- To what extent has the idea of recovery been commodified by some and turned into a product that they sell to others?
- Policy failure exists where two policies are introduced which conflict. This is a problem in Scottish mental health policy where the policy on recovery is in conflict with that which calls for the use of Integrated Care Pathways (ICPs). ICPs base a set care pathway on a specific diagnosis. Whereas a recovery focused practice would base care on an individual's needs rather than their diagnosis.
- Service users are worried that recovery is being used as a 'trojan horse' by government to go in and cut services and leave service users on their own.
- It seems from some of the statements which the government makes about recovery that recovery is only about improving patient services, when it should be much more than that. It should be the basis of everything.
- Are indicators the antithesis of recovery?
- General Practitioners are not part of the recovery dialogue. This is a big gap in the system and an area of silence in our report.
- The growth of the internet at the same time as the SRN was launched was a big factor which aided the extent to which the work of the network could spread.
- As the report says, it was important for recovery to move into policy. The problem with that is that the freedom to interpret recovery at a local level is to a certain extent lost.
- The process of recovery moving from a social movement into policy in Scotland was something that happened organically – it could not be replicated in another system.

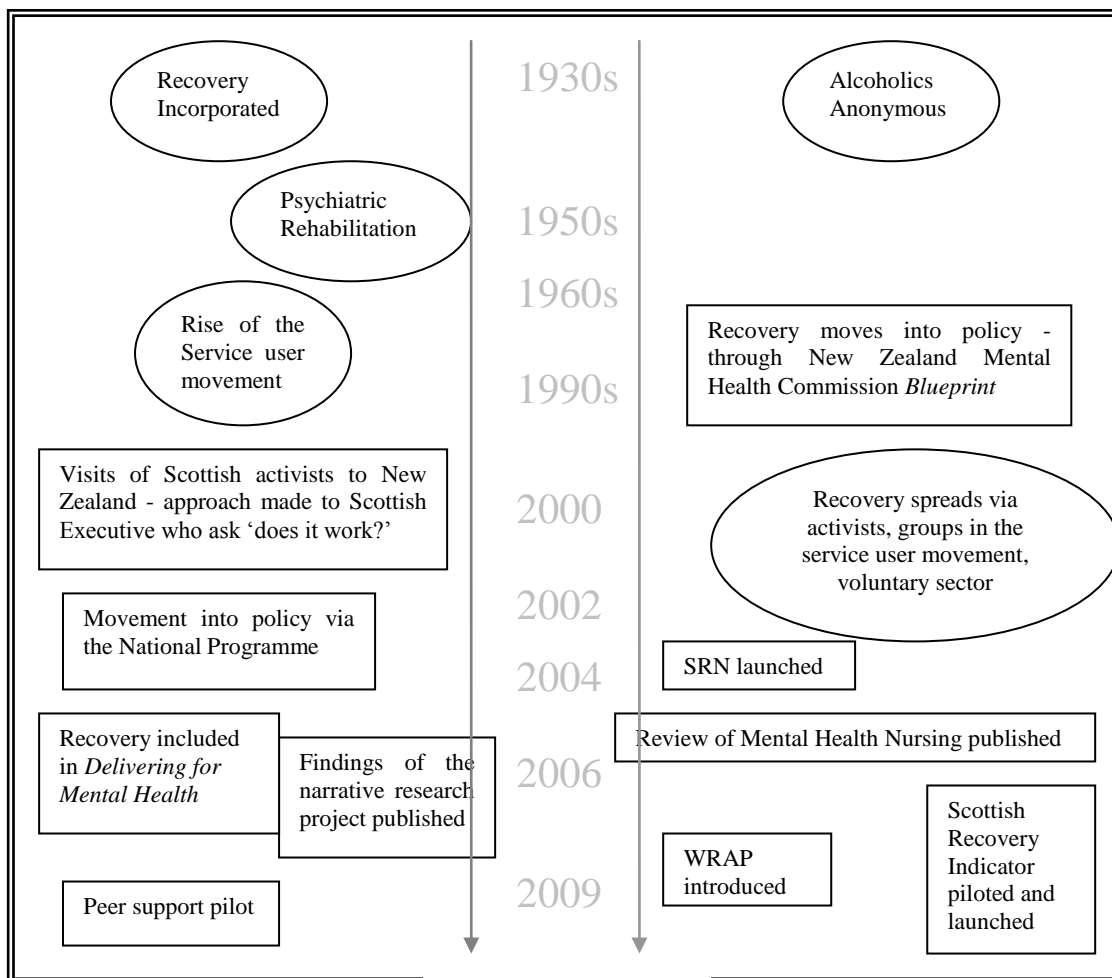
- The key 'technologies' of the system – SRI, WRAP and peer support – originated overseas, but have become Scottish. It was about taking things from overseas and using them as inspiration for what might take shape in a Scottish context. It wasn't about copying. Now other countries are coming to Scotland and seeking inspiration from the work that is happening here.
- Recovery is vague, so how do you see it? You have technologies that provide the evidence to see it. But what is seen is structured by the technology for seeing.
- *Which* service user community has the recovery movement been sourced from? At one point a key issue was whether recovery was being interpreted or promulgated as mainly focused on individuals' recoveries, rather than reflecting collective experience and activism.
- To what extent did the international connections central to IIMHL serve to shape the technologies that were taken up as part of the institutionalisation of recovery within a Scottish context?

Appendix 2: Comparison Zones

The comparison zones are particular questions through which the KnowandPol teams seek to make comparison between their case studies. Some of the comparison zones are very relevant to our case study, but others are not and we were not able to provide much information in relation to those. It would distort our case study were we to pay very much attention to issues that were not prominent within our case. It is essential that these comparison zones are read in relation to the report - they make no sense without the context given in the report.

Comparison zone 1:

A heuristic time scheme of the public action. How can we summarise in a figure the dynamic of the public action?



This table tracks at which point in the history of recovery different parts of the story emerged.

* Oval shapes represent community-based recovery work. Rectangular shapes represent movement of recovery into policy. Timeline is not to scale.

Comparison zone 2:

Paradigm shift. Why do you consider the public action as a paradigm shift?

This public action can be considered a paradigm shift in a number of key ways.

Old/new discourses:

The shift of recovery from social movement into policy marks the establishment of a new discursive regime in mental health policy making in Scotland. This discursive change forces a reconceptualisation of the way individuals - both as staff and service users relate to one another - as it necessitates a reconsideration of knowledge about what represents good practice in treatment. Both staff and service users must go on a journey of recovery through which they come to reconceptualise themselves in relation to mental health and ill-health and 'orient' themselves towards recovery. Staff - psychiatrists, nurses, managers etc. - must change the way they relate to service users so that they base their therapeutic practice on an individuals specific needs rather than the diagnosis they are given.

Core events:

We argue that the shift of recovery into policy in Scotland is an example of a successful social movement. Recovery developed within the international service user movement and gradually moved into Scottish policy via a set of critical steps. The first amongst these was the move into policy in New Zealand via activism of service users within the Mental Health Commission in the 1990s. Over the next 10 years there was a number of visiting exchanges between Scottish and New Zealand which served to communicate the utility of recovery within national policy. The next key step was ongoing discussions about recovery within the service user movement and voluntary sector in Scotland which served to promote recovery as an acceptable concept. These discussions eventually led to the establishment of the Scottish Recovery Forum (SRF, later Scottish Recovery Network) which was incorporated into the first stage of the government's mental health promotion strategy, the National Programme for Improving Mental Health and Wellbeing. Key to its inclusion in this programme was the appointment of Gregor Henderson, formally a member of the SRF as director of the programme. Recovery was then included in several other key policy documents and commitments made to the development of key technologies such as the Scottish Recovery Indicator and the peer support project. These technologies, when implemented within the practices of services served to orient services towards recovery practice.

Structural changes:

Structural changes can be seen as relating to the changes in relationships between staff and service users discussed above. Also the implementation of new regulatory technologies such as the Scottish Recovery Indicator.

Comparison zone 3:

Knowledges and knowledge holders in conflict. What are the conflicting knowledges? Who are the conflicting knowledge holders? What are the factors explaining their competitions?

Superficially it appears that there is a conflict between psychiatry and recovery. However our respondents pointed out that while some psychiatrists might initially be against the introduction of a recovery approach in that they believe that it might conflict with their authority, this does not last. Recovery, once implemented within a service, takes all staff on a journey where they come to realise that recovery makes for better practice. The initial conflict is based around psychiatric training which has a heavy emphasis on diagnosis as compared to recovery, the doing of which is based on an individual's needs and understandings.

Comparison zone 4:

Knowledge policies. How do the policy makers try to influence the conditions of knowledge production in the course of the public action?

Level of Influence:

Policy makers directly influence knowledge production through their sponsorship of the Scottish Recovery Network (SRN) which is wholly funded by the government as a key part of the National Programme for Improving Mental Health and Wellbeing.

Forms of Influence:

Policy makers seek to create knowledge in order to justify their recovery focus. This is done through the introduction of particular technologies such as the narrative research project and the Scottish Recovery Indicator. This legitimates the initial policy choice and further action on recovery.

The SRN is supported as a key vehicle for the bringing together and dissemination of knowledge on recovery. It brings people together through events to talk about recovery, trains individuals in recovery and creates documents that speak about recovery. All of these parts of the SRN's work aim to spread the recovery message to different parts of mental health system.

Comparison zone 5:

Knowledge and policy constellations. What are the constellations where knowledge and policy unite?

We focus in on four key technologies through which recovery is implemented. These could be understood as knowledge and policy constellations. In relation to the six forms of 'constellations' given in the KnowandPol comparison zone guidance our report clearly identifies the development of indicators and best practice as examples of these constellations.

Indicators: the Scottish Recovery Indicator.

The Scottish Recovery Indicator is a tool which services use in order to gauge the extent to which they are implementing recovery oriented services. As our report identifies it has a strong focus on self-evaluation and process. It becomes a tool by which services can start to orient themselves towards recovery through the discourse that members of staff and service users engage in through going through the steps of filling out the tool. The Scottish Recovery Indicator thus enacts a type of governance that relates to processes of self-evaluation and discursive regulation.

Best practice: the narrative research project.

The narrative research project seeks to find out what recovery means in a Scottish context. In doing so it develops a Scottish understanding of recovery which allows those within Scotland to 'own' a concept that has come from elsewhere. As such it is another discursive tool.

Comparison zone 6:

Knowledge in the wider public sphere. How do different types of knowledge get articulated in the wider public sphere?

There is little public debate around recovery - it is still at this stage restricted to discussion within the sphere of mental health services and mental health promotion.

Comparison zone 7:

Local actors in the central decision making process. How do local actors directly and indirectly influence the central decision making process?

There is limited involvement of local actors in central decision making processes in our case study.

Local actors are involved in central processes through central committees and through the dialogue at events hosted by the government around recovery.

Comparison zone 8:

Circulating patterns beyond the borders of the sector and the country. Do policy makers (decision makers, civil servants, idea-brokers, scientists, experts) refer to policies of other countries or sectors as good/bad practices in the debates? What other kinds of international knowledge do they refer to? How do they do this and with what intentions?

There is extensive interaction with international knowledge evidenced in our discussion of recovery. The concept of recovery mainly originated in the US before becoming a central theme within the international service user movement.

Within our case study the connection with New Zealand, discussed in depth in the report, was a central factor which facilitated the knowledge Scottish actors had about the possibilities of recovery. There was a tradition of reciprocal visiting by Scottish and New Zealand policy actors. Much of this was facilitated by the International Initiative for Mental Health Leadership (IIMHL). They also look to England, the US and Canada for comparisons and inspiration.

Our research revealed a process whereby actors set up the understanding and implementation of recovery in Scotland as being in contrast to the implementation of recovery within the US. This was especially prominent in the discussions around the findings of the narrative research project and the construction of the Scottish Recovery Indicator tool which was based on the US-devised Recovery Oriented Practices Indicator tool. Here the Scottish take on recovery was viewed as being less mono-cultural, more community-centred, more process driven and less based on external audit than that in place in the US. This was similar to how those in New Zealand spoke about their version of recovery in relation to that in the US. It was not clear however, that there were in fact serious differences between the New Zealand and Scottish versions of recovery and that enacted in the US.

Scotland in turn has become a site for 'inspiration' for other countries, with the SRN hosting frequent visitors from overseas who wish to find out about the Scottish way of implementing recovery.

Comparison zone 9:

Europe. What role does Europe (and its different institutions and organisations) play in the circulation of knowledge participating in the public action under study?

Europe does not play any significant role in this public action. The most important international actor identified in our research is the International Initiative for Mental Health Leadership.

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