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Recovery in Scotland: the rise and uncertain future of a mental health social movement.

Abstract

‘Recovery’ has become a key element in Scottish mental health policy and practice, despite continuing uncertainty over just what is meant by ‘recovery’. This paper draws on social movement theory to explore the processes underlying the growth of recovery in Scotland. Based on documentary analysis and semi-structured interviews with key actors, it looks at the emergence of a ‘recovery movement’ in Scotland, and in particular at how that movement articulated a ‘recovery frame’ that subsequently came to inform policy and practice. It then reflects on the dilemmas posed by this success, as the recovery movement expanded to intersect with state agencies, and the recovery frame was adapted to accommodate the needs of government policy. It concludes that the future of the recovery movement in Scotland will depend on its ability to maintain a sufficiently broad and inclusive framing of recovery even as it becomes associated with specific policies and practice.

Introduction

Talk of promoting ‘recovery’ looms large in mental health policy discussions, especially in English-speaking countries, where there is much talk of a need to implement ‘recovery oriented’ mental health systems and services (e.g. Brown and Kandirikirira 2008; Farkas et al. 2005; Sowers 2005). However, despite repeated attempts to formulate a universally acceptable ‘working definition’ (e.g. US Substance Abuse and Mental Health Services Administration 2011), the precise meaning of ‘recovery’ in this context remains ill-defined and often contested (Bonney and Stickley 2008). Talk of recovery in the policy literature tends to focus on how mental health service users might be expected to experience recovery: most commonly, recovery is described as a personal ‘journey’ with no fixed end-point and no predefined route, in the course of which individuals are enabled to live meaningful and satisfying lives, whether or not they continue to experience symptoms of mental illness (e.g. Frese, Knight, and Saks 2009; Scottish Government 2010). As Ramon and colleagues note in their analysis of Australian and British literature on recovery, such definitions tend to emphasise the kinds of values – notably the provision of individualised, person-centred care and support – that recovery advocates believe should inform mental health care (Ramon, Healy, and Renouf 2007). However, it remains unclear how those values should be translated into mental health policy and practice, despite increasingly sophisticated efforts to specify just what ‘recovery-oriented’ services should look like (Farkas 2007; Farkas et al. 2005).

Some social scientists have sought to understand this lack of clarity in the meaning of ‘recovery’ with reference to the divergent interests of the different actors laying claim to it or the different contexts in which it is articulated. In a study of UK policy debates, for instance, David Pilgrim (2008) points to the different concepts of recovery articulated by traditional biomedical psychiatrists, community-oriented social psychiatrists and dissenting service users. On the other side of the Atlantic, Nora Jacobson (2004) adds a historical dimension by showing how, in the United States, the idea of recovery acquired different meanings, first as psychiatric assumptions about the possibility of recovery were challenged by radical service users, and subsequently as it was incorporated into mental health policy and the wider politics of welfare provision. Such approaches

undoubtedly help to explain the tensions and multiplicity of meanings associated with recovery. But they leave one wondering why such divergent groups should nonetheless have converged in their advocacy of something called ‘recovery’. Thus while Pilgrim (2008) characterises recovery as a “polyvalent concept” providing an “uneasy consensus point” around which different actors could combine to redefine the aims of mental health policy, he says nothing about how that consensus was established and how it is maintained. Jacobson, meanwhile, is primarily concerned with charting the incorporation of recovery into policy, and is more interested in following the shifts in meaning that accompanied that incorporation than in understanding the drivers or processes that made it possible.

The present paper seeks to fill this gap by offering a new account of how and why recovery became so prominent in mental health policy. It does so through a case study of the development of recovery in Scotland. Here as elsewhere, talk of recovery has come to figure prominently in mental health policy debates over the past decade. In addition, Scotland has implemented a growing armamentarium of practices and techniques in the name of recovery (Bradstreet and McBrierty forthcoming; removed for blinding). Such developments are not uncontentious, however; while many hail them as placing Scotland at the forefront of developments in mental health reform, some recovery advocates object that standardised procedures are at odds with the individualised, person-centred values of recovery, which by definition should cannot be identified with particular practices (removed for blinding). Scotland thus provides an interesting site for investigating not just how the concept of recovery came to figure as a focus for policy debates, but also for analysing the social dynamics of alignment and contestation around specific practical instantiations of recovery.

Our analysis draws heavily on theoretical perspectives from social movement theory. It is of course common for recovery advocates and commentators alike to talk about recovery, not just as a set of ideas or values, but as a ‘movement’, either in its own right (e.g. McCranie 2010) or, more usually, as an expression of the mental health consumer/survivor movement (e.g. Frese and Davis 1997; Sowers 2005; Tomes 2006). Such usage registers a widely-held awareness that the growth of recovery as a policy aim owes at least as much to a groundswell of popular pressure as it does to leadership from the policy elite. However, it is rare for commentators to explicate just what they mean by a ‘movement’; and even rarely for them to make use of the analytical and explanatory resources afforded by social movement theory (cf. Brown et al. 2004). Even where they do make such use, moreover, it is almost exclusively in order to analyse the relationship between recovery and the specific aims and interests of the consumer/survivor movement. Thus Jacobson and Curtis (2000) draw on social movement theory when they observe that, as articulated by members of the consumer/survivor movement, the concept of recovery expresses a distinctive identity politics; and Adame and Knudsen (2007) further develop this perspective by exploring how the consumer/survivor movement adopted the language of recovery to articulate an alternative to biomedical discourses of illness and healing. No-one, to the best of our knowledge, has drawn on a rather different strand of social movement theory which focuses, not on the politics of identity, but on the processes whereby social movements expand beyond their original constituency by recruiting new members.

The present paper shows that much can be gained by adopting this perspective. Thus, we are able to offer novel insights into how and why different actors in the mental health policy landscape came to align themselves around the promotion of recovery as a policy goal. We are also able to identify and explain emerging tensions within the recovery movement, and to cast light on the possible futures of recovery, both as a policy aim and as a social movement. Perhaps most interestingly, we are able to

suggest why the very vagueness with which recovery is defined might actually be more an asset than a hindrance to the success of recovery in Scotland.

Social movement theory

Ideas about what can legitimately be understood as a social movement – or, more precisely, about what kinds of social phenomena can appropriately be understood through the lens of social movement theory – have expanded significantly in recent years. Early commentators tended to suppose that social movements are essentially oppositional, extra-institutional, and organised from the grass roots. This view continues to colour much thinking on the topic; according to one recent review, for instance, “Social movements are conscious, concerted and sustained efforts by ordinary people to change some aspect of their society using extra-institutional means” (Goodwin and Jasper 2009:3; see also Tarrow 2011). But scholarly interest in social movements has also developed in other directions. Notably, many commentators are now less concerned to determine what social movements *are* than to understand the processes by which they come into being, develop and decline. And this focus on process rather than definition has in turn led to a much more expansive and inclusive view of a social movements.

Thus it is now widely accepted that participation in social movements is not necessarily confined to ‘ordinary people’, if by that is meant people without access to prevailing power structures and institutional configurations. Health social movements, for instance, commonly involve alliances between lay people and professionals (Joffe et al. 2004; McCormick et al. 2003). They may also include actors embedded within state agencies, forming “state actor-social movement coalitions” which often prove particularly effective in securing positive policy outcomes (e.g. Stearns and Almeida 2004; Wolfson, 2001). Some social movement scholars go further, rejecting the assumption that social movements typically exist outside institutionalised politics, and seeing social movements within as well as without the political establishment (Goldstone 2003). Nick Crossley, in his groundbreaking study of the British mental health service user movement, has gone so far as to suggest that social movements might best be understood, not in terms of their membership or social location, but, following Bourdieu, as “fields of contention” (Crossley 2006) – a formulation that is notably inclusive, and that allows space for diversity and divergence within a larger shared orientation towards political action. One does not have to take on board Crossley’s entire Bourdieusian framework to welcome this move towards understanding social movements, not in terms of the particular constituencies that they mobilise, but in terms of how they work to orient the politics of contention (e.g. McAdam et al. 2001).

This shift in focus is evident also in a concern to understand how social mobilisation occurs, and in particular how and why individuals are persuaded to align themselves with – and lend their time, energy and resources to – the goal of securing a particular social change. Of particular interest to the present paper has been the adoption of the idea of ‘framing’. Borrowing from Goffman’s (1974) conception of frames as “schemata of interpretation”, Benford and Snow, among others, have identified framing as key to social mobilisation (Snow et al. 1986; Snow and Benford 1988; Benford and Snow 2000; Benford and Snow 2005). As Benford and Snow (2000:614) state: “Frames help to render events or occurrences meaningful and thereby function to organize experience and guide action.” A growing body of empirical research has shown how social movements frame social issues in such a way as to imply particular courses of action and particular policy responses (e.g. Cress and Snow 2000; Coe 2009; Moghadam and Gheydanchi 2010; Rose 2011). Meanwhile, Snow and Benford (1988; Benford and Snow 2000) have gone on to identify a number of ‘core framing tasks’

that they see as central to the way that social movements frame social issues for the purpose of mobilising supporters. First is ‘diagnostic framing’ – the identification and characterisation of a shared problem in need of action. Second is ‘prognostic framing’, or the articulation of a common understanding of how this problem should be addressed and solved. And third is ‘motivational framing’, which involves identifying or suggesting a reason why the issue should be acted on; in effect, motivational frames “function as prods to action” (Snow and Benford 1988: 202). Individually and together, these different forms of framing all operate “by simplifying and condensing aspects of the ‘world out there’ ... in ways that are ‘intended to mobilize potential adherents and constituents, to garner bystander support, and to demobilize antagonists’” (Benford and Snow 2000:614). Mobilisation itself is achieved through through ‘frame diffusion’, as a particular action frame expands into new social and cultural settings. Benford and Snow see such diffusion occurring in two ways: either through a process of ‘strategic fitting’, whereby social movement actors engage in “tailoring and fitting the objects or practices of diffusion to the host culture”; or through ‘strategic selection’, which involves “intentional cross-cultural borrowing, with the adopter or importer ... strategically selecting and adapting the borrowed item to the new host context or culture” (Benford and Snow 2000: 627).

As we shall see, this strand of social movement theory provides a singularly effective toolkit with which to understand the growth of recovery in Scotland. In what follows, we will present a narrative of the development of recovery as an action frame that resonated with the aims and interests of a wide range of mental health activists, and that provided a way of guiding and aligning their actions into common channels. In this respect at least, recovery can be regarded as having emerged as a social movement in its own right, and we will speak of it as such throughout this paper. However, we are less interested in arguing over whether or not recovery really is a social movement, than with seeing what can be gained analytically by regarding it as such. As we shall see, those gains are significant.

Methods

This paper derives from a five-year research project looking at knowledge and policy in mental health in Scotland, undertaken as part of a much larger project, KnowandPol, whose aim was to investigate the role of knowledge in policy for health and education across twelve European research sites. The initial stages of our research on this project involved mapping the Scottish mental health policy landscape (removed for blinding), including a series of 42 interviews with individuals prominent in Scottish mental health policy. In the course of these interviews we also sought to identify topics of particular interest for investigating how knowledge creation or mobilisation was involved in or impacted on the development of mental health policy in Scotland. A number of our respondents from these initial interviews indicated that recovery was an area at the forefront of Scottish mental health policy and practice, and suggested that it would be a potentially fruitful topic for further research. We accordingly set out to supplement our data from this preliminary research with a more in-depth investigation of recovery in Scotland, based on detailed content analysis of key documents and a series of semi-structured interviews.

Key texts were located through searches of the Scottish Government website, NHS websites and the Scottish Recovery Network website. We searched for any documents produced in the period between the establishment of the devolved Scottish government and the end of the KnowandPol project (1999 – 2010). A number of additional texts, including some from before the period covered by our literature search, were identified by interview respondents and incorporated into our analysis.

However earlier documents were also analysed through the inclusion of additional texts identified by respondents. The documents were mainly government documents including policy or service guidance, official and unofficial documents produced by NGOs and service user organisations, meeting summaries, minutes and policy consultation submissions. In the end, over thirty such texts were identified and incorporated into the analysis.

Interviewees were selected on the basis of having being mentioned by respondents in the preliminary stages of our research as particularly important in the incorporation of recovery into Scottish mental health policy. On this basis we were able to identify a number of interviewees including government policy makers, practitioners (including those working in psychiatry and as service managers), advocacy workers, activists and service users, thus providing a good balance of the types of roles engaged in recovery policy and practice in Scotland (removed for blinding). The lead author went on to conduct semi-structured interviews of 30 to 75 minutes in length with nine of these individuals, in locations convenient to the respondents. Questions related to the history and implementation of recovery from the perspective of the respondent. Analysis of the results proceeded concurrently with the interviews. Once saturation was reached, in the sense that new interviews ceased to yield new data, no further interviews were conducted (Morse 2000; Onwuegbuzi and Leech 2007). We note that saturation was reached relatively quickly. We attribute this to three factors. First, the mental health community in Scotland is relatively small and closely interconnected, with the consequence that members tend to reproduce a relatively small range of well-rehearsed narratives and opinions. Secondly, the limited range of answers available to our respondents was further constrained by the fact that our research questions focused quite narrowly on the role of knowledge in mental health policy, specifically in relation to recovery. Thirdly, our research into recovery came relatively late in the overall KnowandPol research project, with the consequence that we already possessed extensive data and understanding of mental health policy in Scotland, some of which related specifically to recovery. This prior knowledge further informed and helped to focus the conduct of our interviews and the analysis of the resulting data. Where appropriate, some of these earlier findings have been incorporated into the present paper, and we have cited our previous papers where this has occurred (removed for blinding).

Analysis of the data proceeded through documentary and discourse analysis of the key texts and interview transcripts. As the focus of the KnowandPol project was on understanding the role of knowledge in relation to policy, particular attention was paid to discovering what knowledge was deployed by our respondents and in the documents. This included factual and technical knowledge of mental health, of recovery, and of policy. But it also included knowledge of actors, relationships, and social processes in the development and implementation of recovery. We also paid attention to how that knowledge had developed over time, and the combination of interviews and documents enabled us to begin constructing a history of the growth of recovery in Scotland. The relevance of social movement theory to our analysis became apparent inductively, when we realised that the early years of recovery in Scotland were dominated by service users drawing on their own experiential knowledge, and that only more recently has recovery become incorporated into official policy and practice. We therefore refined our analysis to produce a history of the growth and progress of recovery as a social movement, drawing particularly on the insights that Benford and Snow provide into the role of framing in social mobilisation (Snow and Benford 1988, Benford and Snow 2000).

Results and discussion

Actors' histories of recovery: genealogy and framing

Given the lack of consensus or clarity about just what kind of mental health practices ‘recovery’ might refer to, it plainly makes little sense, from a sociological point of view, to ask just when and where such practices began. Actors in the recovery movement share no such qualms, however, and accounts of historical origins are frequently rehearsed in the literature on recovery. This is unsurprising. The construction of historical genealogies and the election of ancestors can serve a powerful legitimising purpose. By identifying venerable antecedents, recovery advocates not only seek to forge a common identity, but also to highlight the particular values and ideologies that inform their present-day activities. In this respect, recovery advocates’ reconstruction of history can itself be seen as a way of framing mental health in line with contemporary aims and interests, as was apparent from the interviews we conducted with our Scottish respondents.

When asked about the origins of ‘recovery’, many of our respondents recited elements of a historical narrative that would be familiar to recovery activists around the world. Some sketched a history that went back long before the term acquired anything like the meaning or currency it now enjoys in relation to mental health, looking back as far as the ‘moral’ treatment pioneered by the Quaker William Tuke at the York Retreat in the 1790s (Practitioner 2¹; NGO 1; cf. Davidson et al. 2010). But the majority identified more recent origins, pointing especially to the United States and to the peer support organisations such as Alcoholics Anonymous and Abraham Low’s ‘Recovery, Incorporated’ that emerged there from the 1930s (NGO 2; Government 1), or to the psychiatric rehabilitation movement that developed from the 1960s (Community 2; NGO 1; Community 1; NGO 2; Government 1). What these origin stories have in common is an emphasis on the development of mental health practices that stood outside of, and in opposition to, the mainstream psychiatric practice of their time, and that involved a shift away from professional psychiatric care towards service user empowerment.

Take for instance the connection that our interviewees drew with Recovery, Incorporated. Set up in the late 1930s by psychiatrist Abraham Low, Recovery, Inc. was initially intended to provide after-care for patients discharged from psychiatric hospital. Rooted in Low’s neuropsychiatric understanding of mental illness and its symptoms, Recovery, Inc. provides patients with training in behaviour modification techniques aimed at controlling symptoms and thereby facilitating life in the community. For present-day advocates of recovery, however, the technical content of the training programmes is less important than the fact that Recovery, Inc. quickly grew beyond Low’s direct involvement to become a self-help organisation run by and for service users themselves. According to Wesley Sowers, an American recovery advocate, Recovery, Inc. now “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 [of Alcoholics Anonymous], it attempts to empower people to take responsibility for managing their illness or disability” (Sowers 2005: 758; see also Buchanan-Barker and Barker 2008; White 2000).

A similar emphasis on self-help and empowerment can be seen in our interviewees’ invocation of the psychiatric rehabilitation movement. Developing chiefly in the US from the 1960s onwards, psychiatrist advocates of rehabilitation such as William Anthony initially defined it in functional terms:

“...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 et al. 1986:249-250)

Subsequently, however, in a widely cited article that he published in the early 1990s, Anthony moved beyond this vision of rehabilitation to speak of “recovery from mental illness”. Recovery, according to Anthony, is a deeply personal process, rooted in validation of individual experience, empowerment and peer support, and ill served by a psychiatric system that he depicted as anonymous, ineffective and damaging to those it was designed to help (e.g. Anthony 1993: 527). More recent advocates of recovery underline this same transition from the functionally oriented focus of psychiatric rehabilitation to an idea of recovery based in service user groups and oriented towards personal and political ‘empowerment’ (e.g. Jacobson and Curtis 2000).

In locating the origins of recovery in innovations such as Recovery, Inc. and psychiatric rehabilitation, present-day recovery advocates thus construct a genealogy that foregrounds the agency of mental health service users themselves, and stresses their increasing independence from conventional psychiatric services. Our Scottish informants invoked these American origins for much the same purpose. However, when they came to narrate the subsequent development of recovery, it is notable that our informants quickly departed from a US-centric account and instead pointed to other antecedents. Our interviewees placed particular stress on relating the growth of recovery to the consolidation, during the 1990s, of an increasingly powerful and effective mental health service user movement (NGO 1; NGO 2; Rogers and Pilgrim 1991, Crossley 2006). This movement found expression in a proliferation of meetings, conferences and other events, 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 [in Scotland] and abroad” (NGO 1). The language of recovery was quickly taken up in this setting, and discussed in a number of important international forums including the World Network of Users and Survivors of Psychiatry, MindFreedom International, the European Network of (ex-) Users and Survivors of Psychiatry and, more recently, the International Initiative for Mental Health Leadership. Strikingly, our Scottish informants made little mention of the contributions that American service users made to those discussions. Instead, they argued that a number of key service user groups and individual service users from the UK, New Zealand and Canada were pivotal in linking the term ‘recovery’ with aims and ideals that resonated with those of the Scottish service user movement (Community 1; Community 2; Government 1). In particular, four of our respondents identified developments in New Zealand as crucial for the development of the idea of recovery, and for its diffusion into Scottish mental health policy (Government 1; Practitioner 1; NGO 1; Community 2). This privileging of precursors from New Zealand rather than the US tells us much about the values that our Scottish informants wished to identify with recovery.

In 1997, the Mental Health Commission for New Zealand published a *Blueprint for Mental Health Services in New Zealand: How Things Need to Be* (O’Hagan 2004; Mental Health Commission 2007). This was the first time that recovery was specified as a guiding priority for the provision of national mental health services. The involvement of service user activists in policy development was key to this achievement. The first Chair of the Mental Health Commission, Barbara Disley, consulted widely with service users, who ensured that recovery become a key theme of the *Blueprint* (O’Hagan 2004; Government 1; Community 2). One of those service users, Mary O’Hagan, later reflected on what was intended by this. O’Hagan took the view that, as used in the United States, the term ‘recovery’ remained too closely associated with 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.” Service users in New Zealand therefore adopted the term, not to denote the kind of psychiatry-led services that they associated with the US, but rather as a useful “container” which could be employed to express their own preferred concepts and values, including

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). It was these values that the service users sought to have written into the *Blueprint*, which declared that

“The focus of this Blueprint is on a recovery approach in service delivery ... 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 ... 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: vii.)

Scottish recovery advocates’ identification of New Zealand rather than the United States as the principal source for their own conception of recovery reflects a similar concern to ‘own’ recovery, and in particular to emphasise the independence of user-led knowledge and practice from earlier psychiatry-led models of service provision. This is apparent, for instance, in the Scottish recovery narrative project (for more detail see removed for blinding). According to our informants, this project was explicitly intended to “Scottishise” recovery by collecting personal narratives of recovery from service users across Scotland (NGO1; NGO2, Community 2). Significantly, the recovery narrative project was modelled on a similar project – “*Kia Mauri Tau!*” *narratives of recovery from disabling mental health problems* – that had taken place in New Zealand in 2002 (Lapsley et al, 2002). According to our respondents, an important motive for emulating the New Zealand example by adopting a narrative project in Scotland was to distinguish Scottish recovery from the American version, which was seen as “more mono-cultural”, less “community centred” and less flexible with regard to personal situations and needs than what was being developed in New Zealand (NGO1 and NGO2).

Whether or not this negative portrayal of how recovery had developed in the United States is accurate is not the point here. Rather, what is important is the way that service users both in New Zealand and in Scotland projected a particular image of America as a means of exemplifying values and practices that they did *not* wish to see enacted in their own countries. Seen through the lens of Benford and Snow’s (2000) account of how social movements frame problems as a means of social mobilisation, we can understand this ‘othering’ of American recovery as in effect a rhetorical move in a more general reframing of the problem of mental health along lines that accorded with the aims and values of mental health service user movements in New Zealand and Scotland. Previously, mental health policy and practice had been understood within a predominantly psychiatric frame, which diagnosed mental illness as the problem and identified the exercise of psychiatric authority as the preferred solution. The idea of ‘recovery’, as exemplified in the New Zealand *Blueprint* and the “*Kia Mauri Tau!*” narrative project, involved a very different framing: excess psychiatric power was now framed diagnostically as part of the problem, while service users’ individuality, autonomy and personal experience became part of the prognostic framing, as key values around which mental health services needed to be reoriented. The idea, first articulated by Mary O’Hagan in New Zealand and subsequently echoed by our Scottish informants, that this involved appropriating the very term ‘recovery’ from an excessively psychiatry-led American rehabilitation movement, gave additional rhetorical bite to this reframing. The contrast with America, whether or not it was based in reality, served to further emphasise the agency of service users and problematize existing mental health services. In so doing, it provided a useful shorthand to express the values and expectations of the service user movement – a striking instance of what Benford and Snow (2000: 627) call ‘strategic selection’ of an idea from one frame and its adaptive incorporation into another.

The fact that our Scottish informants looked to developments in New Zealand rather than the US when identifying immediate antecedents to their own activities thus tells us much about the radical and emancipatory that the Scottish mental health service user movement associated with the concept of recovery. Our Scottish informants can be seen as constructing a historical narrative or genealogy that served to legitimise their own activities, aims and values, and that helped to frame the problems of mental health in line with the interests of the service user movement. This is borne out if we now look at how the language of recovery actually came to be incorporated into Scottish mental health discourse.

Recovery comes to Scotland

While the 1990s saw the growth of a service user movement in the UK with many of the same aims and values as its New Zealand counterpart (Community 1), the term ‘recovery’ does not appear to have been widely used in Scotland during that period. Rather, service user groups such as the Hearing Voices Network and the Highland Users Group (HUG) discussed and advocated approaches to mental health that a number of our respondents would retrospectively identify with a recovery orientation (NGO 1; Community 2; NGO 2; Community 1). For instance, a 1998 report by HUG highlighted what kinds of service its members would expect from a satisfactory 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”
- (Highland Users Group 1998)

It was not until 1999 that such aims and values began to be explicitly identified in Scotland with the word ‘recovery’. That year saw the publication of *Recovery: An Alien Concept* by Ron Coleman, a Scottish service user prominent in the service user movement. Coleman was concerned that existing mental health services were so pervaded with an idea of mental illness as intractable that most people diagnosed with mental illness health did not think that recovery was possible (Community 1); recovery had become totally ‘alien’ to the mental health system (Coleman 1999). Coleman’s book, which advocated a very similar user-led approach to service provision to what was being promoted in New Zealand, was crucial both in domesticating the language of recovery in Scotland and in associating it with the aims and values already being articulated by the service user movement. Coleman proved to be a very effective proselytiser for recovery, not just in Scotland but abroad. As one respondent commented: “Ron Coleman has been a kind of lynchpin of recovery in the world” (NGO 2).

Thereafter, talk of recovery quickly gathered momentum in Scotland. Several of our respondents (Community 2; Community 1; cf. Scottish Development Centre for Mental Health 2002) spoke of the importance of a discussion at the Visions and Voices conference held in Dundee in 2001, which culminated in a decision to establish a Scottish Recovery Forum. This initiative was spearheaded by a small group of representatives of service user organisations, mental health charities and research organisations (Community 1). The aim of the Forum was to establish a network “to help create and promote further opportunities for sharing experiences, learning and understanding the recovery process in Scotland” (Scottish Government 2002), and it proved highly effective in placing recovery firmly on the mental health agenda in Scotland (Scottish Development Centre for Mental Health 2002). It also marked something of a transition in the status of recovery. Until that point, recovery had served in effect as a useful term with which to rebrand many of the aims and values that the service user movement had already been promoting under other names. Increasingly, however, recovery was now coming to be seen as an movement in its own right, that attracted adherents from beyond the confines of the service user movement.

A key event in this respect was a 2002 workshop and national dialogue event on recovery which set out to consider “the many different ways of thinking about recovery” and to discuss what kinds of services were needed in order to help to promote recovery (Bradstreet and McBrierty 2012). The event generated considerable interest across Scotland, attracting an audience of over 100 participants. Importantly, the participants were drawn, not just from the service user movement, but also from various governmental and non-governmental service providers, and the audience was more or less equally divided between statutory agencies, voluntary organisations and people who attended as individuals (Scottish Development Centre for Mental Health 2002: 3). The report of the workshop, published later that year, tells us much about how the event was organised, and for what purpose. Although the report was published under the title *Would Recovery Work in Scotland?* it gives no indication that the organisers had any doubts that it *would* work. The formal presentations that opened the workshop do not appear to have raised any critical questions about the effectiveness of recovery, nor to have provided any empirical evidence to counter such questions. Rather, as one of the main organisers announced at the start, the workshop was “about supporting existing work on recovery and starting new work to build good practice” (Scottish Development Centre for Mental Health 2002: 3). Far from being an evaluation of the possibilities of recovery, it was an opportunity to build support and spread the word.

In this regard, it is striking how closely the organisation and content of the workshop conformed to Snow and Benford’s (1988) account of how social movements seek to mobilise adherents by projecting a particular framing of a social problem and its proposed solution. The workshop opened with a series of short presentations that each addressed the question “What is recovery?” and that each offered a similar framing of recovery as the preferred solution to the difficulties experienced by those who experienced mental health problems. Diagnostically, the problem was presented, not as one of mental illness, but rather as a lack of “hope” and “control” (Scottish Development Centre for Mental Health 2002: 3) that tended to be compounded rather than relieved by “the effects of the mental health system” (Scottish Development Centre for Mental Health 2002: 4); as Ron Coleman put it in his presentation, “People need to recover from the system, not their mental health problem” (Scottish Development Centre for Mental Health 2002: 5). The corresponding prognostic framing accordingly cast recovery as the means of addressing this problem by “enabling individuals to take charge of their own lives with the support which they require ... empowering people to make real choices for themselves” (Scottish Development Centre for Mental Health 2002: 3). In consequence,

the organisers argued, the mental health services needed to be thoroughly reoriented around recovery, in such a way as to:

- “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)

Strikingly, the meeting and report also offered what Snow and Benford call “motivational framing”, in the form of the personal story of an individual whose difficulties had been exacerbated by the treatment she received from the mainstream mental health services, but whose life had been turned around when she found more recovery-oriented support:

“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?’ Being part of self-help groups and the Hearing Voices Network was a liberating experience and the start of a journey towards recovery.”

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

Following these presentations, the participants broke up into discussion groups to consider, first, the question “what does recovery have to do with me?”, and secondly to address issues raised by participants themselves. Again, the workshop report does not record any critical examination of the framing of recovery as the solution to the problems of mental health, and it would appear that the discussions were conducted squarely within that frame. The report ended by outlining “ways ahead”, not just for “people already committed to recovery”, but also “for others who have yet to ‘get the message’ of recovery” (Scottish Development Centre for Mental Health 2002:12).

The succeeding years have seen a continuing stream of conferences, meetings and other ‘talking events’ where service providers, researchers, NGOs and service users can meet to talk about recovery and to spread the recovery message to others (Community 1; NGO 1; Community 2; NGO 2). Such events have been crucial to the continuing diffusion of the recovery frame in Scotland, and they appear to have been effective in mobilising a growing number of recovery advocates and activists. One respondent, for instance, 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)

A number of our respondents, meanwhile, suggested that they had found the idea of recovery attractive because it resonated with and succinctly expressed ideals that they were already seeking to put into practice in their own work:

“...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] 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)

In consequence, an increasingly wide range of actors came to agree with the view that mental health provision should be reoriented around the values of recovery, while recovery became an accepted

language for representing the values that many wished to see expressed in the mental health services. The recovery frame was diffused well beyond its origins in the mental health service user movement, and was now being deployed by a growing range of service providers – both statutory and non-governmental – and, increasingly, by policy makers. In effect, recovery had gone beyond being just one among a number of ways of expressing the values of the service user movement, and had become a social movement in its own right.

Recovery in policy and practice

It is an indication of the success of that movement that recovery was quickly incorporated into official Scottish government mental health policy. In 2001 the Scottish Executive (established in 1999 following the creation of the Scottish Parliament, and renamed the Scottish Government in 2007) introduced the nation's first population mental health strategy under the title of the National Programme for Improving Mental Health and Wellbeing (hereafter the National Programme). Gregor Henderson, a mental health researcher and campaigner who had been closely involved in the creation of the Scottish Recovery Forum and subsequent meetings (Community 1; Community 2), was appointed Director of the National Programme. According to a number of our informants, Henderson's appointment was crucial to the adoption of recovery as an official policy priority by the Scottish Executive (Community 1; NGO 1; Community 2; Bradstreet and McBrierty 2012). Recovery certainly loomed large in the National Programme, which published its first action plan in 2003. "Promoting and supporting recovery" was listed as one of four "key aims" for action over the next three years (Scottish Executive 2003:2); and the action plan also announced that the National Programme would support and fund "the development of a National Recovery Network for Scotland" (Scottish Executive 2003:6). According to the action plan:

"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."

- (Scottish Executive 2003:6)

The Scottish Recovery Network (SRN) was duly launched in December 2004 under the direction of Simon Bradstreet, another community activist who had been closely involved in promoting recovery in Scotland. In effect, the SRN took over the work previously undertaken by the Scottish Recovery Forum of promoting the development and diffusion of the recovery frame within Scotland. One of our respondents explicitly equated this with building a 'movement' for recovery:

"[SRN is] a network in that we are a pretty loose association of organisations and individuals so a lot of 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, emphasis added)

Government support also enabled the SRN to explore additional ways of developing and diffusing the recovery frame. As we have seen, the National Programme action plan proposed that, among its other activities, the SRN would "collect and disseminate relevant national and international evidence and material on recovery" (Scottish Executive 2003:6). Accordingly, one of the first initiatives undertaken by the SRN was the preparation and publication of a series of discussion papers on topics that included "Researching recovery from mental health problems" (Berzins 2004), "Elements of recovery: international learning and the Scottish context" (Bradstreet 2004), and "Recovery and community connections" (Connor 2004). The creation of a documentary evidence base helped not only to reinforce the recovery frame but also to recast it in a format that was more acceptable within

the Scottish policy environment. From its initial inclusion in the National Programme, recovery thus became increasingly firmly embedded in mental health policy in Scotland, being adopted as a central element in a succession of policy documents including the review of mental health nursing *Rights, Relationships and Recovery* (2006), the planning document *Delivering for Mental Health* (2006), and the new population mental health strategy *Towards a Mentally Flourishing Scotland* (2009).

The adoption of recovery as a policy aim also helped to pave the way for the development and implementation of what we have elsewhere described as ‘recovery technologies’ (removed for blinding). These are specific practices that recovery advocates see as instantiating the aims and values of recovery within mental health services. Our respondents identified four such recovery technologies as particularly important in rolling out recovery in Scotland. These were: the collection and dissemination of ‘recovery narratives’ (discussed above); the development of the Scottish Recovery Indicator (SRI); the adoption of the Wellness Recovery Action Planning (WRAP); and the formalisation of peer support. Each of these technologies served to diffuse recovery into the mental health system in different ways.

The personal recovery narratives collected by SRN through the recovery narrative project resulted in publications that helped to spread the recovery message throughout the mental health sector. They not only provided a further means of exemplifying and disseminating the recovery frame – particularly the ‘motivational framing’ of recovery as effective relief from the distress of mental illness – but also helped to build an evidence base that could be used to justify the adoption of recovery as a policy goal in Scotland. Other mental health organisations have since followed SRN in collecting and publishing recovery narratives (removed for blinding).

Meanwhile, the other three recovery technologies impacted more directly on how services are organised and delivered. WRAP, developed by US-based service user Mary Ellen Copeland, is used in the context of in-patient and community mental health services and self-help groups to help service users to assess their own needs and strengths and to plan their own route to recovery (Cook et al. 2009). ‘Peer support’ involves the employment of service users within mental health services in order to ‘model’ recovery, demonstrate to both service users and staff that recovery is possible, and help steer the reorientation of services towards recovery. And the SRI is a self-assessment tool, adapted from an American model (Mancini and Finnerty 2005), for staff working in mental health service delivery to assess the extent to which their particular services embody a recovery orientation. The fact that all three of these technologies were partly modelled on or inspired by practices in the United States is at first sight rather surprising, given our respondents’ claims that the development of recovery in Scotland was modelled on initiatives pioneered by the New Zealand service user movement as an antidote to excessively psychiatry-led American models of recovery. However, as we document in more detail elsewhere, considerable efforts were made, under the auspices of the SRN, to ‘Scottishise’ each of these technologies by making them more service user-centred, less bureaucratic, and more oriented towards the realisation of recovery values than towards the delivery of specific kinds of services (removed for blinding). In Benford and Snow’s terms, we can see this as another instance of ‘strategic selection’ and ‘strategic fitting’ of tools from one action frame to another.

The adoption of recovery into official Scottish Government mental health policy, and in particular the activities of the Scottish Recovery Network, have thus been highly effective in achieving further diffusion of the recovery frame from the mental health service user movement to a much wider constituency of actors. A key step in this diffusion has been the adoption and promotion by

government and the SRN of a number of new ‘recovery technologies’, which not only serve to instantiate and exemplify the values of recovery in practice, but have also been effective in extending the recruiting mental health practitioners and service providers into the recovery frame. This is striking evidence of the success with which the Scottish recovery movement was pursuing its goals. At the same time, however, our interviews indicated a degree of ambivalence and sometimes even hostility among our respondents regarding the direction in which recovery was developing, both as a set of ideas and practices and as a social movement.

Emerging tensions

At issue was who should own recovery. The financial links between SRN and the Scottish Government were a matter of particular concern in this respect. Officially, the SRN is a non-governmental organisation, hosted and run by the mental health charity Penumbra. As one of our respondents emphasised, this arms-length relationship with government has been crucial in enabling the SRN to operate as an inclusive network that brings together voluntary bodies and individuals who would have been less enthusiastic about dealing with an official government body (NGO 1). As another observed, official endorsement of recovery had done much to further the dissemination of the recovery frame:

“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 [is] that everybody has been able to hear that message and I think that was really important.” - (Community 1)

But the same respondents also expressed a concern – echoed by other interviewees – that the recovery agenda in Scotland had become too close to government, and was losing its connection to the service user movement that had initially championed it (NGO 1; Community 1; NGO 2; Community 2). Where recovery had started as a “grassroots movement”, we were told, the agenda was increasingly being “driven by the centre rather than local groups” (Community 1).

Recovery activists’ concerns about the ownership of recovery were not merely proprietary. Importantly, they came down to an anxiety that, as a result of the incorporation of recovery into official policy and practice, it was coming to serve rather different aims and interests from those originally intended by the service user movement. Thus, as one respondent put it:

“I think unfortunately along with [the adoption of recovery as a policy goal] 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)

For this respondent, the worry was that the institutionalisation of recovery led to a standardisation of practice that was at odds with the idea that recovery should be tailored to the needs of each individual service user. In particular, this respondent feared that recovery technologies such as the SRI would lead not just to standardisation but to bureaucratisation of recovery (Community 1). Under the wrong circumstances, another service user opined, the SRI might be turned into an audit tool for regulating and standardising services in a way that would hinder rather than promote the kind of open-ended patient-centred support originally associated with the recovery framework (Community 2). Our Scottish Government respondents seem to have shared such fears, one of them

insisting that the SRI “should be a system for people to improve and change services rather than scoring and condemning them” (Government 2).

Some of our respondents went so far as to express a concern that, while the terminology of recovery was being adopted by policy makers and service providers, what was actually being implemented was not really recovery at all, at least as it had initially been understood by members of the service user movement (Practitioner 2; Community 1; NGO 1; cf. Bonney and Stickly 2008; Tilley and Cowan 2011). Official usage of the term ‘recovery’, one respondent argued, was no more than an empty rhetorical gesture: “They use it to rename wards. But I say to them, ‘recovery is a verb, not a noun’” (Practitioner 2). Others even hinted that there might be more cynical motives behind policy makers’ appropriation of the language of recovery, which they feared could be used to justify cuts in services by shifting responsibility for mental health back onto service users (Community 2; Community 1).

The same respondents also worried that government policies encouraged professional take-over of recovery, in a way that tended rather to disempower than to empower service users:

“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.”

- (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)

Here too, the adoption of certain recovery technologies was seen as especially problematic. WRAP, for instance, had initially been developed by Copeland with the expectation that service users would facilitate the work of drawing up their own personal action plans. Increasingly, however, that role was being taken on by mental health service staff, in a move that one service user saw as “further evidence of the colonisation of a process” that had originally been user-led (Community 1). For this recovery advocate, WRAP was something of a Trojan horse; despite the inclusion of ‘recovery’ in the name, it actually reproduced the values of the system that recovery was intended to replace. Just as bureaucratisation was seen as threatening to undermine the original meaning and aims of recovery, then, so too was professional colonisation. For recovery to work, our respondents argued, service users needed to be free to shape it around their own individual lives and needs; but professional control, like bureaucratisation, diminished their ability to do so (NGO 2; Community 2).

All of these factors have meant that the adoption of recovery into government policy and mental health practice has led to a growing tension within the Scottish recovery movement. In a sense, the movement has been a victim of its own success. Recovery activists have been very effective in diffusing the recovery frame outwards from its original base in the service user movement to mobilise support among a growing constituency that now includes service providers and policy makers as well as service users. Increasingly, the movement has come to be centred on the government-sponsored Scottish Recovery Network, in what we can see as an instance of the ‘interpenetration’ of social movements and state organisations (cf. Epstein, 2007: 506). At the same time, however, the recovery frame has itself developed and changed, notably with the inclusion of new technologies such as SRI and WRAP among the armamentarium of ‘recovery oriented’ solutions it now offers for the problems of mental health. In effect, as the recovery movement has penetrated the world of official policy and practice, so the recovery frame has been partially re-aligned, through processes of ‘strategic fitting’ and the ‘strategic selection’ of new techniques, with

the requirements and expectations of that world. This has in turn led to growing ambivalence on the part of many within the recovery movement. Unsurprisingly, that ambivalence focuses in part on the adoption of new recovery technologies from the USA, which, despite efforts to ‘Scottishise’ them with a greater emphasis on patient-centred support rather than psychiatric control, are seen by some recover advocates as introducing elements that are more in keeping with the psychiatry-led and bureaucratic approach to mental health services that recovery was supposed to replace.

Opposition to the adoption of these recovery technologies has been particularly vehement among those members of the mental health service user movement most opposed to psychiatric and other institutional responses to mental ill health and most insistent that any acceptable solution can come only from service users themselves— a group that some of our respondents referred to as an “angry edge” of activists (NGO 2; Community 1; NGO 1; Government 3). It remains unclear how the “angry edge” of the recovery movement will react to the continuing official adoption of recovery. While some respondents feared that they would foment wider resistance towards what they saw as the hi-jacking of recovery by an agenda that they did not approve of (NGO 2), others suggested that they were more likely simply to withdraw from the recovery movement in order to develop a more radical vision of mental health that was more closely aligned with the values of the service user movement (NGO 1; Community 1; Government 3). As one respondent put it:

“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)

Just as the recovery movement emerged from and expanded beyond its origins in the service user movement, it would appear that a new movement is beginning to form as some recovery movement members look for a new way of reframing mental health that will once again prioritise the role of service users themselves in determining how their own mental health needs are to be met (see also Edgley et al. 2012). What form such a frame will take, and whether it will enjoy anything like the success of the recovery frame, remains to be seen. In the meantime, despite the ambivalence of some members and the withdrawal of others, it would appear that the existing recovery frame still resonates strongly with service users as well as service providers and policy makers. As such, it seems likely that the recovery movement, strongly interpenetrated as it is with the Scottish Government, will remain a potent force within Scottish policy on mental health for some time to come.

Conclusions: recovery as a social movement

In this paper we have used the lens of social movement theory to view and recount the growth of recovery in Scotland, from its beginnings in the mental health service user movement to its present position as a key element in Scottish mental health policy. Thus we have shown how the idea of recovery was first adopted in Scotland as a way reframing the problem of mental health to reflect the aims and values of service users. But as we have seen, the recovery frame was not only of interest to service users; it also diffused into new social spaces, attracting a growing constituency of reformist mental health professionals and policy makers, who shared many of the values of the service user movement, and who saw recovery as a way of advancing those values. At the same time, these new actors also began to implement new techniques and new forms of mental health care in the name of recovery, thereby refitting elements of the recovery frame in ways that better suited the needs of mental health service providers, but which alienated at least some of the users of those services. In many respects, this narrative reinforces the views of Pilgrim (2008) and Jacobson (2004) that

‘recovery’ does not denote any single, determinate set of mental health practices, theories or values; rather, the precise meaning of recovery depends to a considerable extent on who is talking about it, and the context in which it is being discussed. However, our use of social movement theory, and specifically of that strand of social movement theory that looks at the mobilising role of framing, enables us to go beyond this deconstruction of recovery, and to consider how and why different actors and constituencies should have aligned themselves with the recovery movement. If we are to understand the rise of recovery, then, there is little to be gained by asking what recovery actually *is*, in the sense of what kind of mental health practices it implies. But much may be gained by asking how recovery works as an action frame that serves to align and mobilise activists and mental health reformers from a broad range of constituencies.

Our use of social movement theory also enables us to throw light on a particularly puzzling aspect of the rise of recovery, namely the fact that it has been widely endorsed, adopted and incorporated into policy, even while what is meant by recovery remains unclear and contestable. As we have seen, ‘recovery’ has never been defined with any great degree of clarity or specificity; rather, its use in mental health discourse serves chiefly to denote a set of rather general values, including the empowerment of service users and scepticism regarding the role of organised mental health services. Seen as a way of framing the problem of mental health, recovery – it least in its earlier stages – was at best only loosely articulated, and included little in the way of specific recommendations for mental health policy or practice. Consequently, it could readily be adapted to accommodate not only the aims and values of service users but also those of service providers and policy makers: in the language of Benford and Snow (2000), it could be ‘strategically fitted’ to a range of contexts and practices beyond those with which it was originally associated. It would appear that the lack of clarity with which recovery has generally been defined, far from being a handicap, may actually have been an asset, at least in terms of building a recovery movement.

In this respect, our findings mirror the observation of Ilana Löwy (1992) that ‘loose concepts’ may sometimes provide a more effective basis for building interdisciplinary alliances in the sciences than tighter ones, since they can be interpreted to suit the particular interests of different actors. By the same token, it would seem that loose framings may sometimes be more effective in building social movements than tighter ones (see also McCormick et al. 2003). Of course, that does not mean that all loose concepts or ‘loose framings’ are equally capable of sustaining a successful social movement. Looseness is only a virtue within certain limits. Any framing, if it is to be effective as a means of social mobilisation, must also offer a sufficiently clear diagnosis of the issues to be addressed and a sufficiently compelling account of the aims and values to be pursued. The recovery frame seems on the whole to have struck a fortuitous balance: it is unequivocal in identifying excessive psychiatric power as part of the problem of mental health, and in advocating service-user-led services as the preferred solution to that problem; but it is generally vague enough, in specifying just what such services should look like, to appeal to actors from a wide range of backgrounds.

The continuing vigour of the recovery movement will almost certainly depend upon whether it can maintain this balance as implementation comes to focus more tightly on the promotion of specific policies, practices and ‘recovery technologies’. There are clear indications that some actors, at least, see this as a betrayal of the aims and values that they originally associated with recovery, and are increasingly inclined to abandon both the concept and the movement. What this means for recovery remains to be seen. Some social movement theorists have identified official co-optation of movement aims, methods or activists as one of the reasons why social movements may decline, as those elements of the movement with a more oppositional motivation become disillusioned and disengaged

(e.g. Miller 1999); while Archibald and Freeman (2008) suggest that this is a particularly common problem for movements that originate as ‘self-help or mutual aid’ organisations. Certainly, something of the sort appears to be occurring in the case of the Scottish recovery movement. This does not necessarily mean the end of the recovery movement, however. It may be that, despite the increasingly close association of the recovery frame with particular mainstream practices and technologies, it will remain sufficiently aspirational in its values as to mobilise continuing calls for reform of services – in which case the recovery movement will survive the secession of some of its more radical activists to become increasingly firmly embedded as a still effective alliance of activists, professionals and state actors. Alternatively, it may be that as recovery loses some of the definitional looseness that up till now has served it well, it will also lose its potency as a diagnostic and motivational frame – in which case, there are already suggestions that it could be replaced by a new ‘post-recovery’ frame and movement. Clearly, social movement theory does not enable us to predict the future of recovery. But it does enable us to envisage some of the different futures that may be in store, and to understand what kinds of factors may determine which of those futures comes to pass.

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¹ Throughout this paper we refer to respondents using a signifier that combines the category which best represents the position they were speaking from, plus a numerical identifier: e.g. ‘NGO 2’. Those identified as ‘NGO’ had their main employment in the NGO sector; those identified as ‘Community’ were working mainly as unpaid advocates for service user organisations and so forth; ‘Practitioners’ were qualified professionals working as service providers; and those identified as ‘Government’ were employed in local or Scottish government policy and administration posts. We realise that these designations are somewhat arbitrary: individuals commonly occupy multiple positions within the mental health field community, for example as both government worker and community activist or as NGO worker and service user. Indeed, beyond noting their principal employment, it would be invidious to try to identify the whole range of positions and identities that any particular respondents might occupy and represent. Consequently, our designations provide no more than an approximate, if occasionally suggestive guide to the various interests represented by our respondents. Given the impossibility of specifying in advance any hard-and-fast classification of our interviewees, all of the interviews followed the same basic schedule of questions, with follow-up questions being determined by the interviewees’ initial responses.

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