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Recovery in Scotland: Beyond service development

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Abstract
Over the last ten years there has been significant activity related to the promotion and support of recovery in Scotland, much of it linked to the work of the Scottish Recovery Network. A range of government policies have consistently identified recovery as a guiding principle of both service design and mental health improvement efforts. New learning has been developed and shared, workforce competencies reviewed and training developed, and a range of national initiatives put in place. In Scotland, as elsewhere, these efforts have tended to focus primarily on ensuring that mental health services offer environments and practices that support personal recovery. While service improvement is crucial, a wider challenge is ensuring that opportunities and support for self-directed recovery are enhanced outside statutory services. Providing examples, this paper will look at the development of recovery in Scotland – including the work of the Scottish Recovery Network – and consider the potential for building on progress made by rebalancing efforts to support personal recovery, highlighting the importance of public attitudes and community-based learning approaches. We will also touch on the role of identity in personal recovery and consider cultural issues related to the promotion of recovery in Scotland.

Early development of recovery in Scotland

The adoption of recovery as a driving force for Scottish mental health policy and practice developed as a result of a number of specific influences from around 2000 onwards.

Following devolution from the UK government, key policymakers and advisers, most notably Gregor Henderson in what was then known as the Scottish Executive, were keenly aware of international activity around recovery particularly in the USA and New Zealand (Slade, this issue, Editorial). They combined this knowledge with the opportunities presented by devolution, to innovate and set a particularly Scottish policy direction. This renewed sense of direction and distinctiveness from UK policy was described in one paper as 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 et al., 2010, p. 11).

This new direction was later heralded in the National Programme for Improving Mental Health and Well-Being (Scottish Executive, 2003b). This innovative and visionary policy introduced a population-wide approach to mental health improvement and included 'promoting and supporting recovery' as one of its four key aims. Initially there was not a clear sense of how this aim might be realized but it was indicated that any activity should be wider than mental health services. This would not only reflect the population approach of the wider National Programme, with its aspiration of mental health for all, but also recognized at an early stage the need to better support recovery outside the confines of a largely treatment service dominated support system. This is a subject we will return to in this paper.

At the same time, outside policy development circles there was an increasing demand for system change and a better recognition of the possibility of recovery. A number of these early recovery advocates came together at events and forums including Hearing Voices Network conferences. At these events, people with experience of significant mental health issues and recovery, including activist and author, Ron Coleman (Coleman, 1999) spoke openly and powerfully about their journeys and the need for systems to be more orientated towards the process of personal recovery. This tradition of first person narrative, so important in the international recovery movement, has been a key driver throughout the story of recovery in Scotland.

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In addition to supportive policy leads and an increasingly vocal activist and service user voice, a third important early influence was the voluntary sector. A variety of third sector organizations – including the former Scottish Development Centre for Mental Health, Penumbra and the Scottish Association for Mental Health – played an important role in sharing messages of recovery and encouraging new learning. Indeed, the Scottish Development Centre were entrusted with the early development of the Scottish Recovery Forum to bring people together around recovery and examine ways in which the fourth key aim of the National Programme might be realized. That the voluntary sector embraced recovery approaches is perhaps not surprising given the close alignment of recovery values to those of person-centredness, particularly emphasized in that sector, but what recovery also seemed to offer at that time was a means of better articulating a sense of dissatisfaction with the support offered to people experiencing mental health problems. The messages of recovery and a developing shared commitment to helping people to be all they could be offered a more constructive means of voicing long-standing concerns.

A series of events and meetings brought people from all interests together to meet and discuss what recovery might look like in Scotland and, indeed, to ask 'Would recovery work in Scotland?' (Scottish Development Centre for Mental Health, 2002). Interestingly the Forum, which was later to develop into the Scottish Recovery Network, was again informed and supported by international experience and advice, this time in the form of representation from the Boston Center for Psychiatric Rehabilitation. This tendency to learn from wider experience at the same time as developing a specifically Scottish perspective and understanding was described by Tilley & Cowan (2011, p. 98) as a 'dual drive', where: 'On the one hand, ideology and evidence from other countries were drawn on. On the other hand, an effort was made to discern or produce, document and promulgate specifically Scottish aspects of recovery. This may reflect a commonplace of Scottish political and cultural life: the good of watching carefully a process e.g. south of the Border, learning from mistakes made there, then fashioning a better Scots version.'

A Scottish Recovery Network

This merging of different approaches, influences and interests, supported by learning from international experience, was to set the tone and approach for the new Scottish Recovery Network (SRN), borne out of the recovery forum and launched in 2004 with funding from the Scottish Executive.

The Scottish Recovery Network's initial aims, which have remained largely unchanged throughout its lifetime, were to:

- Raise awareness of recovery from long-term and serious mental health problems.
- Develop our understanding of what helps people recover and stay well.
- Build capacity for recovery by contributing to the development of the values, conditions, environments and relationships that support recovery and well-being (Scottish Recovery Network, 2005).

An important aspect of the Network – which was established to form a centrepiece for the promotion and support of recovery in Scotland – was that while it was government funded it was not part of the government, but rather operated as an autonomous and independent entity hosted by an auspice agency, the voluntary sector organization Penumbra. This allowed some distance from government for the translation and realization of recovery concepts and values from 'social movement to policy goal' (Smith-Merry et al., 2010). This degree of independence has allowed SRN to act in a way that brings different interests together around a shared vision for recovery as described in the independent evaluation of SRN where the Network was described as 'a '*catalyst*' and *'pump primer'*, a *'bridge-builder', 'facilitator'* and *'collaborator'* (Griesbach et al., 2010, p. 49).

At an early stage it was agreed that translating recovery principles and values to shifts in attitudes, behaviours and practices, both within service-using and service-providing communities, was a significant change process. In recognition of this, SRN's initial emphasis was very firmly upon awareness raising, research about the recovery experience and network building. This was designed to ensure an adequate constituency of support for the adoption of ideas and approaches that in some quarters were considered risky, if not even dangerous. It was felt that without increasing the understanding and commitment to these principles and concepts that the subsequent shift to implementation of recovery tools and practices would have been more easily dismissed as a passing fad, and implementation hampered by a less than enthusiastic mental health community.

Early concerns in Scotland about the promotion of recovery centred on the potential for recovery to offer 'false hope' to people who may not recover. Concerns were also voiced over the potential for the promotion of recovery messages to encourage people to stop treatment. In other quarters resistance was articulated more in the sense of 'we're doing this already' or in the suggestion that recovery was a new iteration of the anti-psychiatry movement. These concerns were largely allayed through SRN concentrating early efforts on raising awareness of the ongoing nature of

recovery, in the presence or absence of symptoms, and on the development of a large-scale narrative research project that both increased and shared learning at the same time as garnering credibility for SRN (Griesbach et al., 2010; Smith-Merry et al., 2011).

Building and sharing the evidence

When SRN was established, there was strategic agreement that an early priority was to learn more about the experience of recovery in Scotland. We took inspiration from ground-breaking and influential studies and first-person narratives of recovery, particularly from the USA and New Zealand (e.g. Lapsley et al., 2002; Ridgway, 2001), but we could not assume that the experience of recovery was necessarily the same in Scotland. Conscious of the strong connection between first person narratives and the development of recovery approaches, both in Scotland and internationally, we developed a large-scale narrative research project designed 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 & Kandirikirira, 2007, p. 6).

Findings from this study, which was based on the analysis of detailed interviews with 64 people across Scotland who described themselves as being in recovery or recovered from a long-term mental health problem, largely echoed international findings about the process of recovery and its underlying themes and principles (Adams, 2011). This included a clear identification that recovery was considered an ongoing journey or process rather than an event or end point. The findings also identified a range of internal and external factors that were described as helping or hindering recovery, with the role of community engagement and meaningful activities as well as recovery-supporting relationships highlighted. It also identified the role of turning points and the process of reframing experiences.

While identity has been highlighted in similar studies (Lapsley et al., 2002) it was perhaps the extent to which it was consistently identified across participants that marked it out as a subject of particular relevance to Scotland: 'Re-finding and re-defining one's sense of self was as important to recovery as symptom alleviation' (Brown & Kandirikirira, 2007, p. 38). Contributors described the process whereby they had developed an identity which might be characterized as an identity of illness and how this identity could be built up and encouraged by a number of factors. These included repeated assessments of needs and deficits and a lack of continuity in services, the need to emphasize illness and problems to qualify for disability benefits and the fact that social networks could become dominated by people working with or using mental health services. For many contributors, reconstructing a more positive and holistic identity that recognized problems and challenges but was not founded upon them was key to recovery.

Recovery 'technologies' and policy in Scotland

Following the publication of the narrative research findings, along with a number of associated publications and resources based on the experiences shared (SRN, 2006, 2007), several initiatives were developed to build upon these experiences and help people start to realize and act on the underlying principles and values identified in this foundational study. These initiatives and projects were characterized in a 2011 paper as 'key technologies of recovery that have assisted in the move towards the creation of a recovery oriented mental health system in Scotland' (Smith-Merry et al., 2011, p. 1). They include:

- support for the development of peer support worker posts to complement and enhance existing support and services. This has included the creation of a national training award (Scottish Qualifications Authority, 2010);
- the creation of the Scottish Recovery Indicator – a self-assessment service development tool used extensively across Scotland and more widely. Refined and re-launched as the SRI-2 in 2011 (SRN, 2011b);
- the development of Realising Recovery learning materials aimed at mental health practitioners and used extensively in the reconfiguration of mental health nurse education (NHS Education for Scotland & SRN, 2008);
- a national programme to support the use of the Wellness Recovery Action Plan (WRAP) (Copeland, 1997) through the training and support of over 50 facilitators.

These initiatives have all been subject to independent evaluation (Macduff et al., 2010; McLean et al., 2009; Mclean & Whitehead, 2008; Scottish Centre

for Social Research & Pratt, 2010) with the learning used to enhance and improve approaches. For example, the evaluation findings from of a pilot project to develop peer support worker roles (McLean et al., 2009) was used extensively in the subsequent development of the nationally accredited training award (Scottish Qualifications Authority, 2010) and in the development of the Experts by Experience implementation guidelines (Scottish Recovery Network, 2011a) and enshrined in a variety of Scottish government policies. Most recently Delivering for Mental Health, which was a detailed service design and delivery plan, included specific targets in relation to recovery initiatives such as the use of the Scottish Recovery Indicator tool and the development of peer support worker roles (Scottish Executive, 2006). Following this, a commitment to recovery approaches, including to the use of WRAP, was reiterated in the population-level policy document, *Towards a Mentally Flourishing Scotland* (Scottish Government, 2009). Prior to these two key documents a supportive policy environment had been established via the National Programme for Mental Health and Well-Being, with its key aim to promote recovery (Scottish Executive, 2003b) improvement and conveys meaning more effectively as well as via the establishment of mental health legislation that was underpinned by a set of principles and included additional rights for people subject to compulsory treatment related to accessing advocacy and supports for social inclusion and well-being in communities (Scottish Executive, 2003a).

The evaluation of SRN suggested it had played a key, even 'transformational', role in supporting the development of recovery approaches (Griesbach et al., 2010). It was aided in this by operating separately from the statutory service sector it sought to influence. Indeed, efforts to introduce recovery approaches in Scotland have been so widespread and universally accepted that some commentators have come to question the extent to which critical debate and reflection have been adequately fostered, suggesting that 'an apparently successful, but not sufficiently argued, case [for recovery] may face perils down the politics road' (Tilley & Cowan, 2011, p. 101).

Building on progress made

While there has been considerable progress made in Scotland, significant challenges remain both in relation to ensuring that mental health services are fully recovery focused, but also in considering and addressing the limitations of promoting and supporting recovery primarily through statutory services. The shift in emphasis required to better realize recovery orientated mental health services was described in the evaluation of SRN as follows: 'The notion of recovery has required a shift in thinking by service providers and service users, to believe that recovery is possible for everyone with a mental illness. And it has required a shift in values and practice, as the role of services therefore has become less to do with "providing care" and more to do with supporting and empowering individuals to achieve their own recovery' (Griesbach et al., 2010, p. 6). This description is helpful in that it highlights that for recovery approaches to be truly realized that there must be a shift in power and responsibility from service providers to communities and citizens (Roe, this issue). However, we believe that this shift in power needs to be more thoroughly negotiated with, and articulated to, people using, or likely to use mental health services. It is one thing for services to shift from care to empowerment but in the absence of an informed and willing service-using community, efforts to this end could have limited impact.

We believe that for recovery to truly realize its potential at a national level then we must work to better support recovery outside statutory services and to enhance learning opportunities. This includes greater consideration of public attitudes to recovery as well as better supporting recovery awareness in community settings, where there are fewer issues in relation to power imbalances in comparison to statutory service settings (Slade, this issue, Editorial; O'Hagan, this issue). In our work we see that opportunities for reflection on issues such as identity, personal development and empowerment flourish in community settings, particularly where mutual learning and peer approaches are encouraged.

Encouragingly, we increasingly see community-based approaches to recovery learning outside statutory services. Services and projects that may previously have primarily offered a degree of companionship and a sense of belonging now work in a way that is more intentionally designed around creating recovery learning opportunities, particularly through peer support and wellness planning, and self management approaches, including WRAP, underpinned by a strong degree of mutuality and empowerment (Health in Mind, 2011; Kinbank, 2011). The challenge is that these very services and projects are the ones which struggle most for secure and long-term funding in comparison to relatively well resourced and protected statutory services.

A 2009 review identified that Scotland spends around £930 million a year on NHS-provided mental health services – a considerable investment in a country of five million people, which does not take account of local authority/social care spend (Audit Scotland, 2009). The same report also suggested that at any one time 850,000 of the population were likely to be experiencing mental health problems, so the need is real. While we are not calling for this spend to be reduced,

we think there may be scope to review how we spend in order to ensure best recovery outcomes. This could involve extending audit work to ensure that recovery outcomes and indicators are assessed and reviewed more fully, and that recommendations for type and location of provision are made as a result.

One of the challenges in disseminating the WRAP in Scotland has been the lack of infrastructure of community-based self-help and mutual aid groups. The underlying values and principles of WRAP are, in part, based on a particular type and location of delivery for WRAP groups, and in our experience it is harder to stay true to these underlying principles within statutory services.

In our experience many people interested in participating in WRAP sessions are motivated by professional, rather than personal reasons. In other words they want to learn more about WRAP so that they can use it in the support they offer to others rather than as a tool to manage their own wellness. It is no bad thing that service providers see WRAP as a good recovery tool and want to make it available to people who use their services, but this can lead to inappropriate sharing of the tool in non-mutual settings. To counter this, SRN have developed systems to manage the expectation and to clarify the primary purpose of disseminating WRAP. This has included developing a statement of principles and better selection of, and support for, potential facilitators who are well placed to use the tool in community settings where opportunities for shared learning and growth – beyond the potential restrictions of mental health services – are maximized. The challenge of creating a stronger infrastructure of community-based self-help and mutual aid groups in which WRAP might be delivered is more significant but perhaps of note for others with an interest in adopting this approach.

WRAP was developed in the USA where there is a stronger infrastructure of community-based self-help and mutual aid groups, perhaps as a consequence of the relative paucity of statutory services than found in Scotland and the UK. We would argue that it is important when importing recovery technologies to give careful consideration to the cultural context of that tool prior to adoption and implementation.

Public attitudes and recovery

The Well Public Attitude survey, which was repeated four times across Scotland between 2002 and 2008, asked samples of around 2000 people to rate their agreement with a series of statements including: 'The majority of people with mental health problems recover'. The proportion of people who agreed with this statement ranged between 50% and 42% over the four surveys (Davidson et al., 2009) suggesting a low expectation of recovery. This is of particular note when you consider the diverse range of mental health issues that participants may have been making internal reference to in rating their agreement with the statement.

Working at a public health level to raise awareness of the likelihood and nature of recovery could, we believe, help create a more informed public who may go on to approach later experience of mental health problems with a greater sense of hope, optimism and control, and perhaps also a greater awareness of their own role in recovery. In Scotland, the SRN has supported this by being developed out of a public health programme and also through working proactively with other national campaigns and initiatives, including the 'see me' anti-stigma campaign and the Breathing Space telephone helpline service, to encourage the dissemination of recovery messages. We believe that opportunities exist to further extend this preventative public health approach including through school education.

The bigger picture

This paper is not intended as a criticism of statutory services in Scotland, which have overwhelmingly embraced the importance of adopting recovery approaches and invested considerable energy in refocusing their efforts. SRN will continue to support the development of recovery-focused approaches across all services, and the Scottish government remains committed to the development of values-based and recovery-focused services (Scottish Government, 2011). Given the enormity of orientating mental health services, policies, values and practices to recovery, it can become difficult to see the bigger picture. Now, close to ten years after the first significant discussions about adopting recovery approaches in Scotland, we believe it is time to ask challenging questions about where we go from here. Within this we would argue that it is important to review the structure and delivery of support for mental health recovery to ensure that we offer the best possible environment and opportunities for the self-reflection and growth that so often characterizes recovery.

Ultimately this might mean shifting resources from treatment to community resources, from hospital to education, individual therapy to supporting mutual aid. Change and suggestions of service reconfiguration are never popular, and at a time of reduced resources professional groups and other interests potentially become more entrenched and resistant to change. We believe, though, that we have a duty to keep asking these hard questions to ensure that the

good progress made is built upon to ensure that as many people as possible in Scotland have the best opportunity to recover a satisfying and fulfilling life.

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