CONCEPT
The Journal of Contemporary Community Education Practice Theory

Vol. 7 No. 3 Spring, 2016

Resilience and Resistance on the Road to Recovery in Mental Health

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Introduction

This article explores the relationship between policy discourses framed around notions of resilience, the influence of the mental health user movement, and the institutionalisation of the recovery model in mental health programmes. This has particular relevance for community education practice. It argues that a spurious consensus has been constructed which conceals competing interests, contested meanings and contentious politics. It concludes by considering what hope there is for reclaiming recovery as a social and political practice which is capable of resisting those neoliberal austerity agendas through which it is currently constructed. Although it is written from the Scottish context, it will certainly have relevance elsewhere.

Resilience has become one of the buzzwords used by social researchers, policymakers, practitioners and community activists alike. For some it offers a common sense framework for negotiating existing and unforeseen insecurities and complexities of twenty-first century lives, particularly in times of crisis (eg Young Foundation, 2011). For others the current focus on resilience, in the policy arena in particular, is a symptom of a much deeper and more widespread crisis (Harrison, 2013). There are, in any case, questions about the nature of crisis, how it is understood, its causes and its effects and is a matter of some debate as to whether an emphasis on resilience adequately addresses these questions. Nonetheless, one of the notable features of contemporary resilience discourse is, indeed, its resilience:

> Some consider building capacity to cope with challenges as pragmatic (and cost effective) policy-making; while for others resilience connotes

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> communitarian ideals such as autonomy from the state, skills sharing and mutual care (Diprose, 2014:47)

As Cornwall (2007) observes, however, 'buzzwords' are often also 'fuzzwords' which defy meaningful definition, but which nonetheless acquire currency, even a degree of consensus, within particular ideological contexts. This article starts by identifying some prevalent narratives or discourses advanced by resilience advocates, and considers what might reasonably be expected of individuals in difficult times, but also what constitutes those difficult times, and the forces that create them. In the absence of an understanding of the wider politics of resilience there is a danger that fatalism or resignation become a substitute for concerted political action to address issues of inequality, injustice and power. This is important because there is a risk that an over-emphasis on resilience 'depoliticises and shifts responsibility for dealing with crisis away from those in power' (Harrison, 2013:99).

This article considers, therefore, whether a renewed emphasis on the recovery model in mental health can be understood as part of a wider resilience agenda that emphasises individual agency over structural factors and their roots in wider socio-economic conditions. The changing role of the state is clearly central to this concern and reflects growing suspicions that the process of moving 'recovery' from the margins to the mainstream in recent times – 'from social movement to government policy' (Smith-Merry et al, 2010: 7) – has reframed it in ways which may have undermined its original meaning. We consider in particular the development of the recovery model through the lens of the mental health user movement in Scotland and elsewhere, and assess the possibilities of rebalancing it to revive the kind of liberatory impulse which animated its original adoption by the wider user movement.

Framing Resilience: Some Prevalent Narratives

Before considering the genesis of the recovery model, and in order to situate our argument within wider welfare strategies and critiques, we identify a number of ways in which resilience has been framed by and within policy discourses and practices, and consider their implications.

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Resilience and wellbeing

It is argued by some influential advocates that wellbeing and resilience are inextricably linked: feeling a sense of control or 'mental toughness' is a precondition for developing a positive 'psychological state'. Conversely, a poor psychological state militates against mental toughness. The Young Foundation Report *The Wellbeing And Resilience Paradox* (Mguni et al, 2012), for example, argues that resilience 'adds an element of future proofing to a wellbeing analysis'. In other words, a good sense of wellbeing that is nonetheless 'vulnerable to future shock' is a limited way of understanding what wellbeing might mean. So, the argument goes, the 'shock' of unemployment may produce a reduced sense of personal wellbeing, but the existence of a good social network and support system can mitigate such negative feelings. In this reading, the creation and maintaining of such a support system is itself confirmation of resilience. Emphasis is thereby shifted from wellbeing as a potential outcome to resilience as an instrumental process.

The convergence between personal resilience and community resilience in recent policy also demonstrates the utility of such an instrumental approach in devising and implementing the 'enabling' trajectory in policy. It could be argued, for example, that the earlier imperative to 'shape places' which 'are nurturing of positive health, wellbeing and resilience' (Scottish Government, 2008:10) is giving way to a focus on 'helping to shape and influence' communities in building their own resilience (eg Scottish Government, 2013:12), thus potentially weakening the structural and environmental dimension of resilience strategies. This shift to community-led solutions is reflected across both statutory and Third sectors, with the development of local Resilience Action Plans amongst policy priorities. As an indicator, and in the context of likely funding cuts following the 2008 financial crisis, by the Spring of 2009 more than 900 Third Sector organisations in the UK reported themselves to be involved in such activities (Harrison, 2013:98).

Resilience and risk

The traditional emphasis on resilience strategies has been in the context of risks from known or unexpected natural forces or sources: weather, flooding, pandemics and so on. However, in recent times 'risk' has been extended to include public disorder, terrorist threats and even economic recession.

Learning to manage risk is at the centre of landmark education policies such as the Curriculum for Excellence in Scotland where the attributes for 'effective contributors' include 'an enterprising attitude', 'resilience' and 'self reliance' (Scottish Government, 2014). Whilst finding strength in self, struggle, achievement and survival is part and parcel of the human condition, there is a danger, as Diprose (2014:52) argues, that 'casting the self as the key site of struggle not only misses the point; it can be exploitative and expose vulnerability' rather than strengthen people against it. Drawing on her research on youth citizenship, she reports that 'rags to riches and reformed rebel stories are fetishised because they prove against-the-odds struggle possible' (p. 52). As she points out, however, failure to meet such exacting standards can result in a profound sense of failure which can be internalised at a personal and social cost in terms of health, self-esteem and violence. It can also serve to justify punitive policy measures and intense surveillance strategies.

Addressing the risks posed by 'terrorism' has also included intense public and private surveillance and, as the name suggests, the Prevent strategy in the UK is partly premised on building resilience to radicalisation, especially amongst young Muslims, irrespective of wider explanations of causation (HM Government, 2011).

In each case, attention is paid to the 'underlying vulnerabilities' which can surface during times of risk and pressure. With equal enthusiasm, such vulnerabilities are also emphasised in relation to more indirect sources of stress 'such as during a recession', which thereby lend themselves to strategies that aim to 'build resilience before [people] hit crisis', as the Young Foundation advocates (2012). The concentration here on personal vulnerabilities or dispositions, however, could also be seen as the devolution of risks which are in fact the consequences of wider economic and political decisions over which people have little or no control and which should

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be matters of urgent political (as distinct from personal) concern. In addition, as Glasby (2011) argues, powerlessness can itself lead to the sense of alienation which finds expression in violence. A wider danger of course is that a particular version of 'normality' becomes hegemonic – no longer questioned.

Resilience and emergency

Another familiar focus of resilience strategies is related to the context of disasters and emergencies. The assumption here is not only that such things are natural, but also that there is a moral imperative to respond in a collective way to them. There is even a suggestion that 'an emergency can bring people together' if they feel that they are 'in it together' (Scottish Government, 2013: 5). In this sense, resilience resonates 'more as a statement of survival than of aspiration' and one that on occasion even entreats people to consider 'man-made crises as mysterious tests of character' (Diprose, 2014:45) and the capacity to 'share the pain'.

A widespread if rather banal example of 'sharing the pain' which is assumed in this narrative, is the invitation extended by local councils to whole populations (with jaunty titles such as The Budget Challenge or Voice your Choice) to respond to fiscal emergency by making their own budget decisions (or incisions), by prioritising 'necessary savings' to be made (eg City of Edinburgh Council, 2014). Notwithstanding practical arguments about who participates, on what basis and with what level of understanding or power, this kind of approach also forecloses on political questions as to how such an 'emergency' has been created, alternative readings of it, or challenges to it. As Slater comments (2014), in this process 'global recession morphs from being a political creation into a naturally occurring phenomenon that requires a programme of public expenditure gutting to set it back on its natural path'. Clearly then there is an important question about what constitutes an emergency and to what ends the dominant definition is framed the way it is. In recent times, the 'financial crisis as emergency' narrative has provided a seemingly open-ended licence for all kinds of restructuring and cuts.

Resilience and self-help

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Perhaps there is most interest, across a seemingly incongruous alliance of advocates, in the idea of resilience as a manifestation of communal self-help. Indeed the 'bounce-back' ability described in some of the most influential versions seems to have attracted a political consensus around the politics of self-help (Diprose, 2014). Suggesting, as it does, prospects for collective agency, autonomy and empowerment, self-help sits at the interface of a number of different and competing interests without drawing attention to the differences between them. Like other protean concepts, it can easily garner support from across the political spectrum. In this respect, the focus on identifying 'inner and innate assets' (SCDC, 2011) associated with this particular narrative is breezily presented as a refreshing break with the 'deficit model' of communities that is seen to have informed previous policies.

These common self-help tropes feed – and feed into – the personalisation agenda that has arguably become the mainstream orthodoxy in UK policy and elsewhere. As Needham (2011:140) argues, personalisation 'can accommodate the managerialism and commodification associated with neoliberal political reforms, whilst also containing elements of the anti-elitism and pro-empowerment of the left.' This partly explains why in social care, for example, the concept can be actively promoted by both the Westminster Government and the service user movement.

At its best, personalisation puts people at the centre of policy (Beresford, 2016). At worst, the personalisation agenda can equate successful struggles for 'equality' with reduction of 'services'. Within a context of contracting public resources, the latter argument can be spuriously deployed to justify closures of day-centres and other community resources presented as positive consequences or evidence of empowerment, resilience and self-help – 'instead of the disastrous result of financial pressures' (Needham, 2013:94). In this sense, and at such times, self-help narratives can act as a 'trojan horse' which (intentionally or not) smuggles in a range of programmatic strategies which are not properly understood until it is too late to halt or challenge them. The assets-based approach can unwittingly serve this agenda by turning legitimate community need into entrepreneurial opportunity: translating a political question about what is needed and how it should be provided, into a personal

one about what communities can offer themselves. As Steiner and Markantoni (2013: 15-16) warn: '*.... at a time of withdrawal of services and wider supports (which possibly lead to the destruction of community resilience) communities are asked 'to do more for themselves'*. If this is the case, community resilience becomes a tool for transferring responsibilities from the state to wider society.

Resilience and good citizenship

Whilst resilience in its manifold forms has been extended to address various policy problems, we would suggest that the conflation of resilience and good citizenship has perhaps the greatest political implications for the most marginalised and powerless in society. This is because it can be 'deployed as an inducement to putting up with precarity and inequality … accepting the deferral of demands for change, and as a means of relocating responsibility' (Diprose, 2014:45). The normative implications of resilience strategies and discourses are that they construct and project what is regarded as 'good coping' and 'bad coping', with commensurate rewards and penalties. As Harrison (2012:103) puts it, "in celebrating the ability to 'bounce back', judgments are made about the quality of people's lives". Such judgments, she goes on, 'perpetuate the view that those who do not succeed (the less resilient) are therefore also less moral' (p104).

Much of the academic literature on resilience focuses on how individuals 'bounce back', 'beat the odds', 'thrive in adversity', 'brace themselves' or 'rebound'. According to the Young Foundation (2012:12), for example, 'whilst resilience may not put money in your pocket when you are lacking funds, it may help you cope with the stress, and reach out to someone that may be able to help in times of need'. This is a particularly apt characterisation of the ideal neo-liberal welfare citizen: one who looks to themselves first and then to those within reaching distance, while the real sources of power remain invisible.

Notwithstanding the critiques summarised above, it is surely no coincidence that, as Diprose, (2014:45) observes, the 'mainstreaming of resilience in policy and politics coincided with the onset and long process of recovery from the worst recession to hit

the UK since the … 1930s' nor that it coincided with 'a sustained austerity drive'. As she goes on, 'a generation came of age and abruptly learned to lower its expectations'.

It is within the politics of the intensive restructuring of welfare that we would also locate current policy interest in what has become known as the recovery model of mental health. This model can be seen as something of a hybrid discourse, combining significant aspects of all the narratives identified above – wellbeing, risk, emergency, self-help and good citizenship – but with its own distinctive features and implications.

Mental Health: Resilience And (The Road To) Recovery

Like resilience, recovery is also subject to both progressive and regressive interpretation, 'because of the idea's inherent ambiguity' (Beresford, 2016:213). In other words, it lends itself well to ideological appropriation in support of competing purposes. Its discursive and programmatic potential is considerable. What may be distinctive, and promising, however, is that the road to recovery – the genesis and development of the concept – has been paved with contestation over the meaning of mental health itself. As Beresford (2016:213) explains, 'it has been presented as a movement, as well as gaining the support of many mental health service users/survivors and their organisations'. It is precisely this capacity for contestation that may offer some potential for reclaiming or redefining recovery as a progressive and positive development for mental health policy in particular, and politics more widely.

The contemporary recovery paradigm has its roots in the psychiatric survivor movements in the USA and New Zealand. It initially emerged as an important corrective to dominant ideas about mental health, specifically to counter the idea that people with schizophrenia had no future:

> … many of us who have been psychiatrically labelled have received powerful messages from professionals who in effect tell us that by virtue of our diagnosis the question of our being has already been answered and our futures are already sealed.

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(Deegan, 1995:92)

This powerful message of defiance – with its emphasis on agency, on people taking control – rapidly spread throughout the English speaking world. Whilst originally a 'professional' model, it is hardly surprising that it also gained widespread interest and support from service users (Beresford, 2016). For example, this is a typical definition, from the Scottish Recovery Network:

> Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of mental health problems or illness, is a unique and deeply personal process.
> (Scottish Recovery Network website)

The concept of recovery in mental health came to Scotland from the USA and New Zealand in 2001 and was taken up with vigour by the Scottish Government. The Scottish Recovery Network was subsequently set up as part of the Scottish Executive's National Programme for Improving Mental Health and Wellbeing (along with *Choose Life*, a suicide reduction campaign and *See Me Scotland*, an anti-stigma campaign) (Scottish Executive, 2003; Smith-Merry and Sturdy, 2010).

It should be emphasised that many of the progressive developments in mental health have emerged at least in part from an active and organized user movement. The service user movement in Scotland had begun in the late 1980s (CAPS, 2010). However, despite some gains, many activists still felt in the early 2000s that they were not being listened to, that services were still abusive, and that they continued to be stigmatised and discriminated against in society and within mental health services. In addition, disproportionately high rates of unemployment, poverty and physical health problems were not being sufficiently addressed. Recovery, with its focus on hope and respecting the experience and aspirations of people with mental health problems

themselves, seemed to connect all the concerns of service users in one positive and effective narrative.

It is also important to note that at the same time as recovery was being adopted by mental health services, other progressive policy developments in health and social care such as social inclusion and personalization (or 'self-directed care' as it is called in Scotland) were also gaining ground. Like recovery, social inclusion and personalisation also originally emerged from disabled people's critiques of health and social care services and similarly used the language of agency, choice and autonomy of the individual (Dodd, 2013: 261).

Social inclusion, for example, was understood as a development of 'deinstitutionalization' strategies following Community Care legislation in the 1990s as a response to criticisms that these had led to the ghettoisation of former patients in group homes and day centres. It promised instead to bring 'people with mental illness into mainstream society, enabling access to ordinary opportunities for employment, leisure, family and community life' (Rankin, 2005, cited in Spandler, 2007).

Similarly, personalisation originally promoted autonomy, choice and control in support services, particularly in the light of increased availability of individualised funding mechanisms. As Dodd (2013:261) comments, 'use of the [personalisation] narrative is typically intended to denote services that are more responsive and personalised to individual needs'. And, in a parallel development, disabled people created the independent living movement so that *'...disabled people [have] the same freedom, choice, dignity and control as other citizens at home, at work and in the community*.... to participate in society and live an ordinary life." (Independent Living in Scotland, http://www.ilis.co.uk/independent-living).

However, just as these developments began to gain support in health and social care policies, the wider context was changing in unexpected ways, and those very narratives which had expressed a more inclusive approach to diversity and difference were seized upon to support an altogether different agenda.

As part of the neoliberal project to redefine the relationship between the state, the economy and society, there was a drive first by the New Labour (1997-2010) and then the Coalition (2010-15) governments to 'reform' both public services and the UK welfare system (Beresford, 2016). In this process, recovery along with personalisation and social inclusion took on a decidedly different meaning. As the National Council on Independent Living (NCIL) put it:

> It seems for many people that independent living is slipping further away. At the same time, national Government rhetoric consistently advocates empowerment, choice, control and personalisation. (NCIL, 2006, cited in Roulstone 2009:336)

In retrospect, it could be argued that recovery, like resilience, had been reframed and appropriated to support the drive to reduce people's 'dependency' on benefits and to promote paid employment as the most significant factor contributing to positive mental health. Some recovery advocates even claimed that benefits and mental health services hindered recovery (eg O'Hara, 2010).

Gradually, therefore, service user groups began to express dissatisfaction with how recovery was being promoted within services (HUG, 2006; CAPS, 2014). Their main concerns were first, that, despite recovery being described as an individual process, people were coming under pressure to recover in ways or in timescales which were neither realistic nor of the individual's choosing. Second, the harsh reality of many people's lives – poverty, side-effects of medication, the increasingly punitive benefit system – were simply not acknowledged. For example, at The People's Conference, an event for mental health service users to give their views on NHS Lothian's Mental *Health and Wellbeing Strategy*, many participants complained they were being 'taught to cope with what is unacceptable in society', whilst some argued that 'recovery need[ed] to be reinvented and reclaimed by people with lived experience of mental health issues' (CAPS, 2014).

In response to what was increasingly being regarded as the ideological colonisation of the recovery model, a group of service users/survivors and their allies created a Facebook group called Recovery in the Bin (RiTB) in February 2014. They describe themselves as 'a User Led group who are fed up with the way … 'recovery' is being used to discipline and control those who are trying to find a place in the world, to live as they wish, trying to deal with the very real mental distress they encounter on a daily basis.' In their statement of 18 Key Principles on Recovery, agreed on 6 February 2015, they explained that they 'reject[ed] the new neoliberal intrusion on the word 'recovery' that has been redefined, and taken over by market forces, humiliating treatment techniques and atomising outcome measurements'. In particular, they identified 'intolerable social and economic conditions … such as poor housing, poverty, stigma, racism, sexism, unreasonable work expectations, and countless other barriers' as the greatest impediments to the kind of recovery envisaged in those early attempts to challenge deficit models of mental health with a more optimistic alternative. The possibilities and problems of the recovery model remain of significant interest, concern and, even, bleak irony. The 19th principle of RiTB, introduced in 2016, for example, reserves the right 'to ridicule and satirise what we dislike rather than always respond with reasoned arguments which can get a bit boring and bad for our mental health'. In this, they are connecting with a proud and popular historical tradition in which mockery and ridicule have been used as powerful 'weapons of the weak' (Scott, 1990)

Conclusion: Can Recovery Be Recovered?

As a result of the way in which the recovery model seems to have been so cynically appropriated, many people who once believed in recovery as a progressive and positive development in mental health policy are now disillusioned, wondering if it can be reclaimed or if it should be abandoned in favour of something more relevant to the experience of those who first championed it. As the Scottish Recovery Network (2010) argue, 'hope is widely acknowledged as key to recovery. There can be no change without the belief that a better life is both possible and attainable'. It would indeed be ironic if the very concept which was developed to express such a sense of hope came instead to express the denial of such hope. The question for mental health

activists is therefore whether there is hope for recovery itself in the contemporary context.

Some argue that 'recovery needs to be reinvented and reclaimed by people with lived experience of mental health issues' in order to ensure that it is not totally colonized and retains some of its positive meaning (CAPS, 2014). Similarly, Recovery in the Bin believes that there are core principles such as 'autonomy and self-determination' that are worth saving (Recovery in the Bin, Article 17). At the same time, Kalathil's (2011) study of African, African Caribbean and South Asian women's narratives of recovering from mental distress makes the case for broadening out recovery to include ways of overcoming socio-political oppression and 'deal[ing] with systemic and structural oppressions that [black women] face in society'. What is broadly agreed, however, is that a concept of recovery that is social and relational rather than simply regarded as an individual 'journey' can only be attained 'through collective struggle rather than through individualistic striving and aspiration' (Recovery in the Bin). For example, many participants in the SRN narrative research conducted by Brown and Kandirikirira (2007:35-36) talked about how important being involved in the user movement had been for their recovery.

What we have tried to show in this article is that recovery, like resilience, has been distorted by neoliberal frames of reference to such an extent that its social and political dimensions, particularly its critique of existing models of mental health provision, can no longer be accommodated. So maybe the focus of struggle and contestation needs to move beyond engaging with psychiatry, whether reforming it or overthrowing it. Perhaps a new recovery paradigm should focus on the development of theories based on both personal and political experience, in solidarity with other marginalized, oppressed or dispossessed groups – learning from each other in the process.

One recent sign of hope has been growing opposition to austerity which is bringing disparate groups of people together to resist cuts to welfare benefits, the NHS and social care services as well as to other public services. Such groups include the wider

disability movement and other users of social care services, refugees and asylum seekers, trade unions and anti-austerity campaigners. These alliances seek not only to defend the welfare state from the onslaught of both neoliberalism and biopsychiatry, but to actively transform it. As Beresford (2016) argues, a new set of principles is required for social policy that makes it more dynamic and participatory – an alternative to both the market and top-down bureaucracies.

However, as McKeown and Spandler (2015) acknowledge, this is by no means straightforward. The history of trade unions in mental health services show that they have not always been supportive of service user campaigns, in some cases arguing that mental patients pose a risk to the public in order to make the case for protecting jobs. But there have also been constructive collaborations, such as the successful Save Lifeworks campaign in Cambridge (Moth et al, 2015), which have been based on positive alliances between user groups and trade unions.

There are other potential alliances to be created too. Professional bodies are being called on by service users and their allies to speak up against welfare and service cuts. For example the British Psychological Society has been urged to condemn the introduction of psychological therapies in job centres (BPS, 2015) and the framing of unemployment as an individual psychological problem. The recent emergence of groups such as the Social Work Action Network, the Critical Mental Health Nurses Network and Psychologists Against Austerity point to a growing unease amongst mental health professionals about what is happening to services, and to the people they are supposed to help. For example, over 400 psychotherapists, counsellors and academics wrote an open letter, before the 2015 UK general election, protesting against the psychological damage that austerity policies were inflicting on their clients and patients, and denouncing as unethical the linking of benefits to receiving psychological therapies (Meikle and Campbell 2015). Such alliances between service user/survivors, trade unionists and professionals involve working together in mutually respectful ways.

A further development, in the form of 'Mad Studies', may be one way of considering experience beyond the narrow confines of psychiatry and recovery. This is an emergent field which not only critiques psychiatry and the medical model of mental health by providing space for alternative understandings of madness, but also moves away from the individual focus of the mental health system to look at collective experience within its wider social and political context. In this sense, 'it is a counterpoint to the history of psychiatry [with an emphasis on] the lived experience of madness' (Church, 2015). As new as Mad Studies is, many of the activists and academics involved are already very aware of the way in which ideas from the disabled people's movement such as independent living and the social model of disability, as well as recovery, have been co-opted by neoliberalism (Beresford, 2014).

Finally, what both anti-austerity alliances and Mad Studies distinctively contribute is an opening up of the understandings of mental distress, and the growth of a movement that looks beyond psychiatry and mental health services. Working with other groups who are similarly oppressed and marginalised by neoliberal capitalism under the guise of anti-austerity allows us to learn from and work with each other. We all have multiple identities and such alliances allow us to work for all of them. Perhaps moving from personal resilience to collective resistance would be one very tangible way of reclaiming recovery as a progressive political practice.

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