

Recovery: an international perspective

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SUMMARY. **Aims** – To review developments in recovery-focussed mental health services internationally. **Methods** – Two forms of ‘recovery’ which have been used in the literature are considered, and international examples of recovery-focussed initiatives reviews. A ‘litmus test’ for a recovery-focussed service is proposed. **Results** – ‘Clinical recovery’ has emerged from professional literature, focuses on sustained remission and restoration of functioning, is invariant across individuals, and has been used to establish rates of recovery. ‘Personal recovery’ has emerged from consumer narratives, focuses on living a satisfying, hopeful and contributing life even with limitations caused by the illness, varies across individuals, and the empirical evidence base relates to stages of change more than overall prevalence rates. Clinical and personal recovery are different. Two innovative, generalisable and empirically investigated examples are given of implementing a focus on personal recovery: the Collaborative Recovery Model in Australia, and Trialogues in German-speaking Europe. The role of medication is an indicator: services in which all service users are prescribed medication, in which the term ‘compliance’ is used, in which the reasoning bias is present of attributing improvement to medication and deterioration to the person, and in which contact with and discussion about the service user revolves around medication issues, are not personal recovery-focussed services. **Conclusions** – The term ‘Recovery’ has been used in different ways, so conceptual clarity is important. Developing a focus on personal recovery is more than a cosmetic change – it will entail fundamental shifts in the values of mental health services.

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INTRODUCTION

There is a developing consensus in English-speaking countries about the importance of recovery. In this paper we provide a history of the term, review important sources of evidence, and outline current policy and practice in Australia and German-speaking Europe. We conclude by identifying key clinical and scientific challenges.

Recovery: a rhetorical consensus

The term ‘recovery’ has become increasingly visible in mental health services. A focus on recovery is advocated as the guiding principle for mental health policy in many

English-speaking countries: Australia (Australian Health Ministers, 2003), England (Department of Health, 2001), Ireland (Mental Health Commission, 2005), New Zealand (Mental Health Commission, 1998) and the United States (New Freedom Commission on Mental Health, 2005). This policy consensus is mirrored in professional rhetoric. In England, for example, the principles of recovery have been adopted by clinical psychology (British Psychological Society Division of Clinical Psychology, 2000), mental health nursing (Department of Health, 2006), occupational therapy (College of Occupational Therapists, 2006) and psychiatry (Care Services Improvement Partnership, Royal College of Psychiatrists, & Social Care Institute for Excellence, 2007). Perhaps the most influential professional group internationally is psychiatry in the United States, which has also embraced the term (American Psychiatric Association, 2005).

This rhetorical consensus conceals a more complex reality. The word ‘recovery’ is used with a range of incompatible meanings, and rational debate is not possible without conceptual clarity. We identify two classes of meaning.

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Clinical recovery

The first meaning of recovery, and the definition traditionally used in mental health services, has to do with sustained remission. This locates the concept within an illness frame of understanding, and equates recovery with long-term reduction or ideally removal of symptomatology, accompanied by functional improvement. The key feature of this definition of recovery is that it is invariant across individuals. For example, Libermann & Kopelowicz (2002) define recovery in schizophrenia as full symptom remission, full or part-time work or

education, independent living without supervision by informal carers, and having friends with whom activities can be shared, all sustained for a period of two years.

This feature of invariance make it relatively easy to operationalise the concept. By viewing recovery as a dichotomous state which can be reliably rated, it becomes possible to undertake epidemiological prevalence studies over much longer periods than is usual in clinical trials. The results of studies in schizophrenia which have assessed recovery over more than a 20-year follow-up period are shown in Table I.

Table I. – Recovery rates in long-term follow-up studies of psychosis.

Study	Location	Year	n	Mean length of follow-up (years)	% Recovered or significantly improved
(Huber et al., 1975)	Germany	1975	502	22	57
(Ciompi & Muller, 1976)	Lausanne	1976	289	37	53
(Bleuler, 1978)	Zurich	1978	208	23	53-68
(Tsuang et al., 1979)	Iowa	1979	186	35	46
(Harding et al., 1987)	Vermont	1987	269	32	62-68
(Ogawa et al., 1987)	Japan	1987	140	23	57
(Marneros et al., 1989)	Cologne	1989	249	25	58
(De Sisto et al., 1995)	Maine	1995	269	35	49
(Harrison et al., 2001)	18-site	2001	776	25	56

To re-emphasise, this kind of research is only possible through viewing recovery in operational and invariant terms. For example, one of the earliest and most widely cited studies was the *Vermont Longitudinal Study* (Harding et al., 1987). The primary criterion for good outcome was a Global Assessment Scale score of over 61, meaning “some mild symptoms ... or some difficulties in general areas of functioning, but generally functioning pretty well...and most untrained people would not consider him sick”. Ignoring the reliability issues and dated language, the meaning is clear – recovery in this study meant having fewer symptoms and functioning in the normal range.

So what does this research mean? The most recent collation of all long-term follow-up studies included over 1,000 patients between 12 and 26 years after initial diagnosis of schizophrenia (Hopper et al., 2007). Commenting on the results, Richard Warner concludes that “Kraepelin’s view that a deteriorating course is a hallmark of the illness just isn’t true. Heterogeneity of outcome, both in terms of symptoms and functioning, is the signature feature, an observation that has profound implications for our understanding and management of the condition ... bad outcome is not a necessary component of the natural history of schizophrenia; it is a consequence of the interaction between the individual and his or her social and economic world” (Warner, 2007).

Despite this emerging evidence, there remains an overall prognostic pessimism in mental health services (Office of the Deputy Prime Minister, 2004). The mismatch can be explained by the ‘clinician’s illusion’ (Cohen & Cohen, 1984), which describes the tendency for clinicians who work with an ambiguous and long-term illness to assume that the presentation in clinical settings is similar to the way the illness looks in the long term and in the general population with the illness. It is an illusion because there is a negative correlation between consulting a clinician and managing the illness successfully.

This illusion leads to a powerful clinical reality, in which low expectations of a good future are communicated to patients (Thornicroft, 2005). Being on the receiving end of this phenomenon has been labelled as ‘spirit-breaking’ by consumers (Deegan, 1990), and directly influences the beliefs of patients: “About two years ago I realised that I really could recover. I find that quite an amazing fact, because over the years no one has actually said, “You can recover”. I thought once you had mental health problems you were just going to be stuck with it” (Scottish Recovery Network, 2006).

This mismatch has led to calls from consumers for a new approach: “The field of psychiatric disabilities requires an enriched knowledge base and literature to guide innovation in policy and practice under a recovery

paradigm. We must reach beyond our storehouse of writings that describe psychiatric disorder as a catastrophic life event and depict people who experience significant and prolonged psychiatric problems as progressively deteriorating, persistently impairing, and in need of life-long care” (Ridgway, 2001). The second meaning of ‘recovery’ provides this enriched knowledge base.

Personal recovery

The second definition has emerged not from the mental health research literature, but from the increasingly coherent voices of individual who have experienced mental illness and used mental health services. Patient narratives have progressed from early accounts of individuals talking about their own experiences (Deegan, 1988; Coleman, 1999; Davidson & Strauss, 1992), followed by compilations of these accounts (Scottish Recovery Network, 2006; McIntosh, 2005; Lapsley *et al.*, 2002), culminating in recent qualitative syntheses (Jenkins *et al.*, 2007; Ridgway, 2001; Lapsley *et al.*, 2002; Jacobson, 2001; Ralph, 2000; Andresen *et al.*, 2003).

The common theme to emerge from these accounts is an emphasis on understanding recovery as something other than the absence of illness markers of symptoms and functional impairment. Probably the most widely-cited definition of recovery from this perspective is as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (Anthony, 1993).

The two definitions of recovery have been variously labelled as recovery “from” versus recovery “in” (Davidson *et al.*, 2008); clinical recovery versus social recovery (Secker *et al.*, 2002); scientific versus consumer models of recovery (Bellack, 2006); and service-based recovery versus user-based recovery (Schrank & Slade, 2007). In this paper we will refer to the first definition as **clinical recovery** to reflect its emergence from the scientific clinical literature, and the second definition **personal recovery** to reflect its individually defined and experienced nature.

Adopting a focus on personal recovery in mental health services

The clinical implications of focussing the efforts of mental health services on the promotion of personal recovery are profound. Key components to emerge from qualitative syntheses are: hope; identity; meaning; and personal responsibility (Andresen *et al.*, 2003; Spaniol *et al.*, 2002; Ralph, 2000). A recent review of the implications for psychiatry of a focus on personal recovery concluded that the factors identified by consumers as important for their recovery include hope, spirituality, empowerment, connection, purpose, self-identity, symptom management and stigma (Schrank & Slade, 2007). In other words, evidence-based treatments targeting symptoms are only one contributor to personal recovery.

Similarly, a consensus-based approach was used in the USA to identify ten characteristics of a recovery-focussed mental health service (Substance Abuse and Mental Health Services Administration, 2005), shown in Table II.

Table II. – Consensus statement on recovery.

Principle	Description
Self-direction	Consumers lead, control, exercise choice over, and determine their own path of recovery
Individualised and Person-Centred	There are multiple pathways to recovery based on the individual person’s unique needs, preferences, and experiences
Empowerment	Consumers have the authority to exercise choices and make decision that impact their lives and are educated and supported in so doing
Holistic	Recovery encompasses the varied aspects of an individual’s life including mind, body, spirit, and community
Nonlinear	Recovery is not a step-by-step process but one based on continual growth with occasional setbacks
Strengths-Based	Recovery focuses on valuing and building on the multiple strengths, resiliency, coping abilities, inherent worth, and capabilities of the individual
Peer Support	The invaluable role of mutual support in which consumers encourage one another in recovery is recognised and promoted
Respect	Community, system, and societal acceptance and appreciation of consumers - including the protection of consumer rights and the elimination of discrimination and stigma - are crucial in achieving recovery
Responsibility	Consumers have personal responsibility for their own self-care and journeys of recovery
Hope	Recovery provides the essential and motivating message that people can and do overcome the barriers and obstacles that confront them

It will be challenging for mental health services to develop these characteristics, many of which are not central to the professional training of any mental health group. The complexity is increased by the emergence of evidence that there are stages of recovery. For example, an Australian synthesis of recovery narratives identified five phases (Andresen *et al.*, 2003):

Moratorium – characterised by denial, confusion, hopelessness, identity confusion and self-protective withdrawal.

Awareness – the first glimmer of hope for a better life, and that recovery is possible. This can emerge from within or be triggered by a significant other, a role model or a clinician. It involves a developing awareness of a possible self other than that of mental patient.

Preparation – the person resolves to start working on recovery, .e.g. by taking stock of personal resources, values and limitations, by learning about mental illness and available services, becoming involved in groups, and connecting with others who are in recovery.

Rebuilding – the hard work stage, involving forging a more positive identity, setting and striving towards personally valued goals, reassessing old values, taking responsibility for managing illness and for control of life, and showing tenacity by taking risks and suffering setbacks.

Growth – [May also be considered the outcome of the previous recovery processes] whether or not symptom-free, the person knows how to manage their illness and stay well. Associated characteristics are resilience, self-confidence and optimism about the future. The sense of self is positive, and there is a belief that the experience has made them a better person.

The type of help and support which promotes recovery will differ depending on the stage the person is in. For example, promoting self-management for someone in the Moratorium stage may give rise to feelings of abandonment.

We now give a perspective on policy and practice in recovery in two countries.

Recovery in Australia

Like the international literature, the concept and policies related to recovery have increased significantly in Australia since 2000, including a specific statement by the federal government in the Australian Mental Health Strategy (Marshall *et al.*, 2007). The Australian Mental Health Strategy 2003-2008 uses William Anthony's definition of personal recovery (given above) as the goal of

mental health services (Australian Health Ministers, 2003) (p. 11).

The understanding of recovery in Australia is most heavily influenced by recovery literature from the USA, but also from Canada and New Zealand. The contributions to recovery from European nations are largely overlooked in Australian policy, research and practice, although dialogues with Ireland and Scotland have recently opened up. The context in Australia is that the federal government formulates national policies, e.g. Australia was the first nation to have a national AIDS policy, and has developed a series of coherent, sequential 5-year National Mental Health Plans. National policies are usually developed through meetings of the Australian Health Ministers, alongside the state and territory governments which have parallel policy documents. However, whilst there has been much conceptual debate and numerous local initiatives around recovery practice in Australia (Rickwood, 2004), there remains significant resistance to the National Mental Health Plan's statement that "*a recovery orientation should drive service delivery*". Some Australian advocates of recovery remain envious of the success of their counterparts in New Zealand in developing a recovery focus (O'Hagan, 2004). Moreover, the national initiative around routine outcome measurement includes measures of symptoms and functioning such as the *Health of the Nation Outcome Scale* (Wing *et al.*, 1998) and the *Life Skills Profile* (Rosen *et al.*, 1989), but totally excludes reference to any recovery-related constructs. The development in Australia of the Stages of Recovery Instrument (STORI) is one example of a promising instrument to measure change from more consumer-related perspectives (Andresen *et al.*, 2003; 2006), as is the recent Australian validation of the *Recovery Assessment Scale* (RAS) (McNaught *et al.*, 2007).

It is important to consider the geographic distances in Australia, making the differences between metropolitan, regional, rural and remote mental health service provision very important. Anecdotally, it was not uncommon to provide training in rural areas as late as 2002 where the majority of mental health staff would state that they had not heard of "the recovery movement". In terms of public mental health services, these services are often referred to as "clinical" whilst the non government sectors are often referred to as "disability" or "support services". This distinction is formalised, for example in New South Wales, with policy and funding separated into "clinical rehabilitation" and "disability support". A further key challenge in Australia is the poor physical and mental health of the indigenous populations. Discussions regarding the relevance of the western individualistic notion of recovery to

indigenous population are complex, with no single answer. However, these discussions often find common ground with concepts of empowerment and self-determination, but less so with recovery if viewed from an individual viewpoint. When involved in these discussions, it is not uncommon to hear phrases such as “Communities can be ill” and “Communities can recover”.

In terms of developing recovery-based service provision, Lindsay Oades has been part of a research team that has trained over 600 mental health clinicians in twelve organisations across four states of Australia in the *Collaborative Recovery Model* (CRM) approach to mental health treatment for people with severe and persistent mental illnesses, such as schizophrenia (Oades *et al.*, 2005). This training was based on a philosophy that people with such mental illnesses have the capacity to lead meaningful and productive lives while continuing to experience significant symptoms of their illness. The team has been delivering recovery-based training for mental health clinicians and support workers from public and non-government organisations throughout Australia routinely since 2003, as part of an National Health and Medical Research Council funded research project called *Australian Integrated Mental Health Initiative* (AIMhi) (Crowe *et al.*, 2006; Deane *et al.*, 2006; Oades *et al.*, 2005). However, training clinicians has not ensured the routine implementation of recovery based practice, with significant difficulties with the transfer of training. Anecdotally, the conceptual and practical uptake has often been easier with the non-government organisations than the government organisations, possibly because the former has had less “clinical training” which sometimes can be antithetical to the philosophies of self-determination and risk taking.

The debate regarding evidence-based practice versus lived experience pervades much of the discourse on recovery in Australia. Moreover, the consumer (user) participation movement in Australia is closely intertwined with, although different from, the recovery movement. Some common ground relates to the claims that the prototype of recovery is the “self-help group”. Hence, consumer-operated service provision with maximum consumer involvement remains consistent with the self-help aspect of recovery. However, one well-known consumer advocate in Australia, who wishes to remain anonymous, argues that the consumer participation movement is not consistent with “recovery” because people make careers from being consumer advocates, and hence their identity remains defined by illness.

In terms of future directions of “recovery” in Australia, it is very uncertain. However, the following possibilities exist:

- National outcome measures will eventually include constructs that are more compatible with consumer views of recovery
- The consumer participation ethos will increase across policy and practice contexts with collateral influence on recovery based practice
- Empirical examination of recovery will continue via approaches such as the aforementioned Collaborative Recovery Model (CRM), and by importing positive psychological variables such as hope and subjective wellbeing, which are empirically measurable
- Funding models that are more consumer-centred rather than institution-centred will grow in popularity
- Comparison and potential integration between the meaning of recovery in alcohol and other drug contexts with that in mental health will increase.

Further development of recovery competencies in the mental health workforces and scientifically respected measurement of recovery-related constructs will probably be the two key factors in the long-term sustainability of recovery consistent values within Australian mental health service provision.

Policy in German-speaking Europe

The endorsement of the concept of recovery in the English-speaking world and the adoption of a bottom-up concept into top-down policy is a phenomenon to which the non-English speaking world has yet to react. In order to do this, one important decision concerns the question whether the term ‘recovery’ can be meaningfully translated. An illustrative example of the dimensions touched on here is shown in the transcript, published under the title *No empowerment without recovery*, of an interview between Christian Horvath (leader of the Viennese self-help organization “Crazy Industries”) and Michaela Amering (Amering & Schmolke, 2007):

MA *Mr. Horvath, for several years now you have argued that patients can be cured in front of several distinguished conference-audiences, which was not always greeted by applause. How come?*

CH *Well, that was interesting. Several psychiatrists felt that the notion of a ‘cure’ was too far-reaching and esoteric. They were concerned about patients who might present them with certain expectations in response to the notion of ‘cure’ which could not be fulfilled. My primary intent was not to promote a cure in a broad sense, but rather to establish a counter-weight to the perennial*

notions of stabilization and relapse-prevention. Dedicating your entire life exclusively to relapse-prevention often leads to a kind of risk-aversion that is not conducive to a balanced life - it makes people go in circles.

MA If cure was not the ideal term, how would you translate and interpret 'recovery'?

CH The easiest way might be to contrast 'recovery' with the notion of 'empowerment'. We had many discussions among our members about this latter term. Recovery means primarily to be concerned with your own convalescence. And empowerment in essence means that your position vis-à-vis psychiatry needs to be destigmatised and improved, even if this requires a great deal of readiness to become engaged in conflicts. Empowerment needs recovery. In my opinion, users who live along the lines of recovery, experience greater realization of their intentions".

(Translation from German to English: Peter Stastny, 2008).

This is a German-language interview that uses the term 'empowerment' as an English term that has been adopted and accepted in the German language as is the case for e.g. 'compliance'. The same might happen with 'recovery', which again is difficult to translate at this stage of development, when through the English-language discourse so much work has been done already to define and delineate the concept as well as the term in its different meanings as outlined above.

Andreas Knuf of *pro mente sana Switzerland* (www.promentesana.ch) was among the first mental health professionals in German-speaking psychiatry to endorse the notion of recovery, mainly through reporting the work of Pat Deegan (www.patdeegan.com). His appeal for a change 'from demoralizing pessimism towards rational optimism' (Knuf, 2004) was followed by Swiss initiatives of users who tell their recovery stories and play an active part in training of mental health workers. This development and resulting publications also used the term 'recovery' – either not translating it or offering the term 'Genesung' as a translation, a term that would usually be translated as 'convalescence' and does not carry similar weight as 'recovery' does right now in the English-speaking mental health discourse.

The 2007 book by Amering and Schmolke introduced the concept of recovery from the English-speaking countries to the German-speaking countries (Amering & Schmolke, 2007). It used the untranslated term 'recovery', and described its roots in the user movement as well as giving policy and research examples. The book has received many positive and hopeful responses from professionals,

users and families. A review in the currently highest ranking German psychiatric journal 'Psychiatrische Praxis' concluded that 'the book is a rather heartfelt plea for well-informed and responsible patients who are taking charge of their lives without resigning to passive compliance monitored by social engineers'. (Steinert, 2007).

This comment points out a background that could contribute to incorporating the recovery concept into policy and mental health service delivery within the framework of current developments in German-speaking countries. Efforts towards a person-centered approach in mental health care have been central to policy and planning for many years, as have developments of integrated and integrative services. The Scandinavian need-adapted approaches (Alanen, 1997) and Soteria projects (Ciompi & Hoffmann, 2004) exert some influence on networks of innovative planning. Also, health promotion and prevention are receiving increasing attention. Empowerment has played an important role in education and orientation of most professional groups in mental health in recent years. The user movement does play some consultative role in policy-making (www.bpe-online.de/english/index-e.htm) and also has a voice in developing and demanding alternatives to the traditional service system (Stastny & Lehmann, 2007).

The 2005 Action Plan endorsed in the Mental Health Declaration for Europe by ministers of health of the Member States in the WHO European Region (World Health Organization, 2005) identifies as one of five priorities for the next ten years the need to "design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery" (p. 2), a demand corresponding to what has been labelled as 'service-based recovery' (Schrank & Slade, 2007). It also prominently includes a call to "recognize the experience and knowledge of service users and carers as an important basis for planning and developing services" (p. 3) and collectively "tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process" (p. 2), which speaks to the principle of user involvement, a main concern of 'user-based' recovery definitions.

An example of an initiative to advance user involvement and user-controlled projects in German speaking countries are the coordination of the Leonardo da Vinci European Union project EX-IN by Bremen, Germany. This involves 14 projects in six countries (Germany, Sweden, Norway, The Netherlands, UK, and Slovenia) aimed at developing and implementing models to use the

lived experience of (ex-) users in teaching and service development (www.ex-in.info). Another example is an organisation which was founded in Berlin in 2002 by a group of long-standing activists (www.faelle.org) and dedicates itself to postgraduate education from the perspective of ex-users, as well as to the pursuit of user-controlled research. Finally, an example from Austria is a project, which has been commended by Mental Health Europe as an “example of best practice”. Former service users can achieve a qualification as “expert through experience” by participating in a peer-coaching training programme, and subsequently offer these services to their peers in the form of counselling, advocacy and peer support. The project has shown positive results in areas beyond self-help and advocacy, including counselling, support and dissemination of information within psychosocial services and school-based projects against stigmatization (www.pmooe.at).

An innovative development, which has long been exclusive to the German-speaking countries, is called ‘Trialogue’ (Amering *et al.*, 2002) or ‘Psychosis Seminar’ (Bock & Priebe, 2005). In Trialogue groups, users, carers and mental health workers meet regularly in an open discussion forum that is located on “neutral terrain” – outside any therapeutic, familial or institutional context – with the aim of communicating about and discussing the experiences and consequences of mental health problems and ways to deal with them. The groups also function as a basis and starting point for trialogic activities on different levels (*e.g.* serving on quality control boards) and different topics (*e.g.* a work group on religion and psychosis) and activities (*e.g.* a trialogic day in the training of police officers with regard to interacting with people with mental health problems). In German speaking countries, Trialogues are regularly attended by approximately 5,000 people. Trialogues are inexpensive, a great number of people seem to benefit from participation, and the movement has certainly brought about concepts and a language different from the still widely prevalent narrow discourse of the medical model of mental health and illness. It is a new and exciting form of communication, an opportunity to gain new insights and knowledge, an exercise for interacting beyond role stereotypes, and a training for working together on an equal basis – accepting each other as ‘experts by experience’ and ‘experts by training’. This is a skill conducive to recovery-orientation as well as involvement of users in therapeutic and service development decisions, which staff in Austria have been shown to be very optimistic about (Sibitz *et al.*, 2007).

Clinical challenges

Whatever a recovery-focussed service does look like, it is clear that an exclusive focus on symptoms and functioning is misplaced (Davidson *et al.*, 2008), and may inadvertently hinder recovery (Slade & Hayward, 2007). Mental health services for people with a psychosis diagnosis illustrate the point. On the one hand, they benefit people experiencing psychosis, by providing treatments which alleviate symptoms and consequent distress and disability (Ruggeri & Tansella, 2007). In-patient admissions and home treatment teams offer a safety net for those no longer able to compensate for disturbance caused by their phenomenological experiences. They are a better alternative for people exhibiting socially abnormal behaviour than the criminal justice system. Mental health staff are, in the main, compassionate and wanting the best for the people using their services.

On the other hand, mental health services and systems also cause harm. Their focus on symptom reduction and crisis management (rather than self-help, psychological or social interventions (Healthcare Commission, 2006)) communicates the message that a ‘good’ patient is a compliant patient, who should follow instructions about medication, accommodation and behaviour. Their disregard of social context (*e.g.* poverty (Henderson *et al.*, 1998), social support (Wynaden & Orb, 2005)) and consequent resources (*e.g.* spiritual (Clarke, 2003), artistic (Rosen, 2007), peer support (Copeland & Mead, 2003)) ignores the link between environment and mental well-being (Drukker *et al.*, 2007). Mental health services provide high levels of compulsory treatment, despite the Mental Capacity Act (2005) in England stating that a person “*is not to be treated as unable to make a decision merely because he makes an unwise decision*” and the empirical evidence of equivalent rates of mental incapacity between psychiatric and non-psychiatric in-patients (Raymont *et al.*, 2004). Mental health staff working with people who experience psychosis have low expectations of improvement, and this therapeutic nihilism adversely impacts upon service users (Cabinet Office, 2006). The ghettoisation of the mentally ill, previously achieved through physical asylums, is now developing in many countries through virtual institutions in the community (Priebe & Turner, 2003). In combination, these factors mean that many people who experience psychosis make rational decisions to avoid services, and once in contact find it difficult to return to a mental health service-free life.

The definition of personal recovery has emerged in part as a means of addressing these criticisms. Embedded in the recovery approach is a critical perspective on cur-

rent power structures and past working practices (Masterson & Owen, 2008). Recovery discourse can therefore be expected to engender a backlash from professional groups whose power is threatened. There have been several responses, including an insistence on symptomatological improvement as the sole indicator of recovery (Libermann & Kopelowicz, 2005), the view that “a redefinition of the term ‘recovery’ in order to give hope is to build hope on illusion” (Oyebode, 2004) (p. 48), and re-labelling rehabilitation services as ‘Recovery and Rehabilitation Services’ without meaningfully changing their function. These responses could be viewed as denial, ridicule and appropriation – all normal responses when existing paradigms are challenged (Kuhn, 1962).

Scientific challenges

Recovery is as much a process as an outcome – it is better conceptualised as a way of living life than as a state to attain (National Institute for Mental Health in England, 2004). This inherent subjectivity means that the objective measurement of recovery in individuals is problematic.

As a direct consequence, determining whether a service is promoting personal recovery is also problematic. How might a recovery-promoting service be recognised? At present, there are few quality standards (Tondora & Davidson, 2006) and no fidelity measures. This is a pressing research issue (Slade & Hayward, 2007). We propose a ‘litmus test’, relating to the use of medication. At present, there is almost universal prescribing of medication for people using specialist mental health services (Office of the Deputy Prime Minister, 2004). However, people using services have wide and sometimes polarised views about the role of medication in their recovery, ranging from pharmacotherapy as a central element to medication being a hindrance to recovery (British Psychological Society Division of Clinical Psychology, 2000). This provides one behavioural marker of the extent to which mental health services are provided on the basis of professional priorities (e.g. the centrality of medication) or on the basis of the more heterogeneous views of individual service users. Services in which all service users are prescribed medication, in which the term ‘compliance’ is used, in which the reasoning bias is present of attributing improvement to medication and deterioration to the person, and in which contact with and discussion about the service user revolves around medication issues, are not recovery-focussed services.

We conclude by recognising the need for more research. Bellack puts it succinctly: “No systematic data are available on rates of recovery from the consumer perspective ... scientific communities have not sufficiently appreciated the subjective experiences of people with schizophrenia and their ability to recover from the debilitating effects of the illness... Conversely, it is not clear if the experiences of consumer-professionals are characteristic of the broader population of people with schizophrenia, or if they represent a distinct good-outcome subgroup” (Bellack, 2006). We have previously identified a series of empirical challenges (Slade & Hayward, 2007):

- 1) Identifying active ingredients of a recovery-focussed service
- 2) Developing fidelity measures
- 3) Establishing national baseline prevalence estimates of the extent to which services are recovery-focussed
- 4) Culturally validate recovery outcome measures
- 5) Methodological developments to assess value attached to outcomes by the individual
- 6) Develop pro-recovery interventions, e.g. to promote hope or personal responsibility
- 7) Develop demonstration sites, as role models to influence system transformation.

However, it would be a mistake to view personal recovery as a purely scientific development. It has emerged from a different source – the lived experience of patients – and emphasises individuality and acceptance far more than empirical evidence. Many consumers are ambivalent about whether the adoption of recovery rhetoric into clinical practice reflects a genuine shift in values (Scottish Recovery Network, 2006). Many clinicians are sceptical about the value of recovery (Davidson *et al.*, 2006). The long-term development of mental health services is unlikely to be primarily determined by scientific findings.

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