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Concept and Model of Recovery

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Introduction

As suggested by this chapter's title, the term "recovery" has come to refer both to a concept and to a model in contemporary psychiatry. In the following, we hope not only to show how these approaches to recovery depart from the more traditional, clinical sense of the term and to clarify the confusions between the two, but also to suggest how the concept of recovery offers the foundation for a significant transformation of psychiatric practice, much of which remains as a hopeful vision to be actualized in the future.

First, we describe the origins of two very different conceptions of recovery, arguing that while they remain distinct, they are also highly compatible, if not complementary. Then we turn to the various models of "being in recovery" [1] or "personal recovery" [2] that have emerged in the field within the last two decades and explore briefly the implications they generate for changing all forms of psychiatric practice, from inpatient care to community-based rehabilitation—a sphere that increasingly incorporates persons "in recovery" as staff (a phenomenon very much related to recovery, as described in detail in Chap. 21).

Recovery as a Concept

Before broaching that form of recovery that is relatively new to psychiatry—dating back to the late 1980s—we begin with the traditional, clinical concept of recovery that goes back as far as the discipline itself. This concept of recovery is imported from medicine and refers to a complete resolution of all of the signs, symptoms, and impairments that had been associated with a person's experience of mental illness. Someone who has recover*ed* either has been cured of the illness or has otherwise found a way to overcome it; while it may have left social-emotional scars, for all intents and clinical purposes, the person no longer has the condition in question. Although within the mainstream, psychiatric perspective, the researchers who concurred on the identification of the criteria for "remission" in schizophrenia stopped short of addressing the possibility of such a complete recovery [3], this notion has a long and distinguished history in the field.

Philippe Pinel, for example, spoke and wrote about this form of recovery in the late eighteenth century, at the dawn of the moral treatment era, as when he told the members of the Society for Natural History in Paris in 1794 that:

> One cannot ignore a striking analogy in nature's ways when one compares the attacks of intermittent insanity with the violent symptoms of an acute illness. It would in either case be a mistake to measure the gravity of the danger by the extent of trouble and derangement of the vital functions. In both

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> cases a serious condition may forecast recovery, provided one practices prudent management. [4]

Despite the widespread belief that he distinguished "dementia praecox" (which later came to be called schizophrenia) from manic depression based on its inevitably deteriorating course over the shortened remainder of the patient's life span, even Kraepelin wrote that "dementia fortunately does not occur in all cases" [5]. In fact, he observed that the possibility of a form of recovery that could be "considered equivalent to cure" was "not at all unusual," as he wrote in this passage:

> The prognosis, however, is really by no means simple. Whether dementia praecox is susceptible of a complete and permanent recovery answering to the strict demands of science is still very doubtful, if not impossible to decide. But improvements are not at all unusual, which in practice may be considered equivalent to cures. [6]

Once the location for longitudinal clinical research shifted from the long-stay hospitals of Kraepelin's time to the community, during and following deinstitutionalization, a heterogeneity in outcomes became established both within and across individuals [7]. That is, a series of long-term follow-up studies of persons diagnosed with schizophrenia conducted as early as the 1970s found up to 67% of their samples to experience significant improvements over time, many recovering fully [8–12]. Among those who did not recover fully, there was a broad diversity in functioning across a number of only loosely linked domains, with some people improving in some areas (e.g., symptoms) while not others (e.g., social functioning) [13, 14]. Only about 33% of these samples showed a course and outcome similar to Kraepelin's predictions, ranging from clinical stability (i.e., little if any improvement) to progressive deterioration. It is an open question as to why these findings related to the possibility of clinical recovery continue to be overlooked by many in the field [15]. It would appear, however, that since there has been a discipline of psychiatry, there consistently have been people who have recovered fully, and many more who have recovered at least partially, from schizophrenia. We can debate the various percentages that might fall into each category, but—and despite the fact that we have yet to discover a "cure"—clinical recovery, as first documented by Pinel, remains a possibility.

Were this all there is to what has come to be called the "Recovery Movement," though there would be no need for this chapter. But beginning in the 1970s, as these more optimistic data on the outcomes of people living outside of hospitals were starting to appear in academic journals, persons who had been hospitalized began to come together to advocate collectively on their own behalf as part of a Mental Health Ex-Patient/Survivor/Consumer Movement [16]. In part as a protest against the dismal prognoses, they had been given, as well as against the poor treatment they had received, members of this movement pushed back against the profession of psychiatry, proposing to create alternatives to the mental health system that were based on self-help and mutual support [17]. By the late 1980s, some people within this movement began to view these "alternatives" as complementary to, rather than as replacements for, clinical and rehabilitative services and began to advocate for conventional care to be reoriented to promote the dignity, self-determination, and sovereignty of persons with serious mental illnesses.

These advocates took up this cause based on their own "lived experiences" of the harm perpetrated by disrespectful and coercive care and of their own struggles and successes of living meaningful and productive lives in the face of what psychiatric professionals described as mental illnesses. There continue to be deep divisions within this community with respect to whether such conditions as mental illnesses truly exist or not and whether collaboration with mental health services and providers is possible without leading inevitably to the co-optation of the perspective of persons with lived experience. Out of the interaction between mental health consumer advocates and progressive mental health researchers and practitioners, though, the "Recovery Movement" was born.

Perhaps the best—and as far as we can find, the first—example of this confluence of perspectives was captured by Pat Deegan, Ph.D., a person who experienced involuntary, harmful psychiatric treatment but then went on to become a clinical psychologist herself. In one of her first publications, Deegan defined and articulated a different conception of "recovery" than that used in clinical research. She wrote that:

> Recovery refers to the lived … experience of people as they accept and overcome the challenge of the disability … they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability. [18]

There are at least two new and important components to this statement that help to clarify the essential difference between this form of recovery and recovery as a clinical phenomenon, as defined above. First, Deegan defines this concept of recovery as grounded in the "lived experience" of persons with mental illness. This is a form of recovery, in other words, that is to be understood from the perspective of the person with the condition rather than from that of the clinician or clinical investigator. Drawing from Deegan's own background in phenomenological philosophy, this shift to first-person experience as a source of credible and useful knowledge laid the groundwork for the development of "lived experience" into "lived expertise." Now a central tenet of the Recovery Movement, the notion of "lived expertise" established the basis for the pursuit and use of the wisdom and practice-based evidence accumulating among persons living effectively with serious mental illnesses. This form of evidence is proposed as being at least equally as valid and complementary to, if not more relevant than, third person, traditionally defined empirical or scientific knowledge about mental illness. As a result, a case is being made for the centrality of "service user involvement" in all types and across all phases of psychiatric research [19], an increasing expectation in psychiatry that parallels the increasing call for "patient," or primary stakeholder, involvement in medical research more broadly [20–22].

The second new and important component of Deegan's highly influential definition is the use of the term "disability" to refer to serious mental illness. This article was published 2 years prior to passage of the landmark legislation of the American with Disabilities Act and in this way reflects what had become a key advocacy strategy of the Consumer/Survivor Movement. If we redefine serious mental illnesses as disabilities under the law, then all of the civil rights and associated responsibilities of community inclusion afforded to persons with physical or developmental disabilities come to pertain to persons with "psychiatric disabilities" as well [23]. While this concept of mental illnesses as disabilities remains somewhat contentious within the broader consumer/survivor community (because it suggests lifelong impairment), the civil rights and community inclusion aspects of the law do not. Rather, they provide a conceptual foundation for the Recovery Movement, which took its inspiration in part from the civil rights movements of persons of color, women, and the LGBT community beginning in the 1960s, as well as more directly from the Independent Living Movement of persons with other types of disabilities, who had been successfully advocating for their civil rights, including the right to community inclusion, since the early 1970s [24].

What are the implications of adopting a disability rights view of the effects of serious mental illnesses? On the one hand, this could simply be a way of characterizing the condition of those people who do not fully recover according to the clinical criteria described above. In other words, if we know that there is a heterogeneity in outcome within and across individuals, some people, those who experience long-term functional impairments, might be described accurately as being "disabled" by mental illness. Perhaps Deegan was referring to those people who do not recover and who therefore continue to have their lives limited and constrained by the symptoms and deficits associated with schizophrenia. They would appear to be disabled in the conventional sense of the term. But on the other hand, Deegan would appear to be referring to something other than being disabled when she writes about such people "recovering a new sense of self and of purpose within and beyond the limits of the disability." How can people who have not yet recovered recover a new sense of self and purpose?

It is in this way that "recovery" for these people is based on the disability rights view articulated in the Americans with Disabilities Act. Persons with disabilities—whether physical or psychiatric in nature—are to be afforded access to a self-determined, full life in the community, as are all other law-abiding citizens, and should "accommodations" be required to afford such access, they are to be provided. By the concept of accommodations, we typically refer to such things as wheelchairs, wheelchair ramps, and handrails in bathrooms that are provided so that persons with mobility impairments will be able to access public spaces as much like everyone else as possible. Similarly, Braille signs and service dogs are accommodations for persons with visual impairments, and sign language for those with hearing impairments. While we are still learning what psychiatric accommodations may end up looking like, adoption of a disability model has allowed advocates such as Deegan to insist that people need not be cured or symptom-free before rejoining community life as full, autonomous, contributing members.

Adoption of this model thus has dramatic and far-reaching implications for how mental health care needs to change to support people in "recovering a new sense of self and of purpose within and beyond the limits of the disability." In addition to reducing symptoms as much as possible, mental health care must focus at least as much, if not more, on restoring functioning and, in areas in which functioning has not yet been fully restored, in enabling people to join in those aspects of community life that they value even while they may remain disabled by a mental illness [25, 26].

This brings us to the second concept of recovery substantially different from, if still somewhat related to, full recovery. As we noted above, this form of recovery—alternatively described as being "*in* recovery" with, as opposed to recovering *from,* a serious mental illness [1], as a "consumer" model of recovery as opposed to a "scientific" one [27], or as "personal recovery" compared to "clinical recovery" [2]—is most applicable to and relevant for those persons who still experience symptoms. This situation has led to innumerable misunderstandings and concerns about [28], as well as uses and abuses of [29], this second concept of recovery and leaves us far from being in an ideal position to discern implications of this concept for practice. Yet that is precisely what we shall do before turning to different models of this form of recovery.

A first implication of this concept is that people with even the most severe forms of mental illness such as schizophrenia remain people first and foremost and are thereby deserving of dignity and respect. In fact, Deegan once wrote: "The concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with a mental illness are human beings" [30]. In order to operationalize this insight—with which no one would disagree in principle—it becomes incumbent upon practitioners to tailor the care offered to the unique needs, preferences, and goals of each person, to provide what has come to be called "person-centered care" [31]. In addition to being person-centered, such care needs to identify and build on each person's unique strengths and both internal and external resources (i.e., be strength-based), maximize self-determination (i.e., be respectful of the right to make treatment and life decisions), actively take into account the person's sociocultural background and identity (i.e., be culturally competent), and capitalize on healing relationships beyond the formal treatment system (i.e., be inclusive of identified natural supporters and "family" as defined by the individual). Finally, care needs to be oriented to empowering and enabling the person to pursue the kind of life he or she wishes to have, and would find value in, within his or her local community, offering environmental accommodations or community supports that may be required to compensate for enduring difficulties associated with the disability. As the 2003 U.S. President's New Freedom Commission Final Report [32] concluded, it is no longer enough to treat symptoms and simply accept long-term disability if more can be done to improve the person's quality of life or, in Deegan's words, to assist him or her in "recovering a new sense of self and of purpose within and beyond the limits of the disability."

From a conventional clinical or scientific view, such things as a sense of self or purpose may sound highly subjective and beyond the scope of the provision of health care per se. The Recovery Movement can be understood, however, as both a social movement and as a movement to bring about what the New Freedom Commission report characterized as a "transformation" of all mental health care [32]. The social movement aims to combat the stigma, stereotypes, and discrimination associated with having a mental illness in contemporary society so that persons with mental illnesses can, in fact, be viewed and treated as human beings worthy of dignity and respect. The call for transformation begins with, but goes beyond, recognition of these persons' fundamental civil rights to promote an approach to care that elicits, encourages, and honors the person's autonomy, capabilities, and valued roles within his or her chosen community. The major responsibility for this form of recovery lies with the person him- or herself but is also understood to be social in nature [33] and to rely heavily on caring and trusted others and on access to welcoming and supportive communities [34].

Within this context, the role of the practitioner shifts from the sole expert who makes decisions about the person's treatment and overall life (e.g., where and with whom people will live, how they will spend their time, etc.) to that of an expert consultant who has information, skills, education, treatments, supports, and other interventions to offer in promoting the person's, and family's, own efforts at recovery. Each party, including the local community, possesses strengths and resources that can be identified and built on in the recovery process, which evolves in many different ways for different people. But to be supported in their recovery, people need to be respected and treated with dignity as whole human beings who are more than just their diagnosis or illness, need to be offered hope, and need to have their cultural identity, values, affiliations, and preferences honored by their health-care providers [26]. Once we have reviewed the different models of this form of recovery, we will be able to add more specificity to what this kind of care looks like in practice.

Models of Recovery

As discussed in the previous section, a major development in broadening the field's understanding of recovery was to distinguish between the two central types, which Davidson and Roe [1] referred to as "recovery from" versus being "in recovery" and Slade [2] as "clinical recovery" versus "personal recovery." The first, "recovery from" or "clinical recovery," refers more to the scientist-practitioner perspective while being "in recovery" or "personal recovery" alludes more to the person's experience-based perspective [35]. In this section, we will describe recent advances in developing models and frameworks of the later form of personal recovery.

In an attempt to create an empirical conceptual framework for recovery, Leamy and colleagues [36] conducted a systematic review which included 97 published papers from which 87 distinct studies were identified (which were selected from over 5000 that were identified and over 366 that were reviewed). Once the articles were selected, efforts were directed at developing a conceptual framework. First, inductive, open coding techniques were employed to identity central themes. Next, analysis focused on the *relationships within* and *between studies*. Finally, a thematic analysis was conducted until category saturation was achieved and was subject to comments by an expert consultation panel. The final conceptual framework comprises three interlinked, superordinate categories: characteristics of the *recovery journey*, *recovery stages*, and *recovery process*es which we elaborate on below.

In all 87 studies, characteristics of the *recovery journey* were identified. By far, the most common characteristic mentioned was recovery as an active process. This was mentioned in half of the studies, suggesting it might be the major hallmark. There is a sharp contrast between recovery as an "active process" in which the person is engaged and the traditional approach to care in which patients were perceived as passive recipients of care provided by others and were limited in what they could do to primarily complying with or adhering to what these expert others had prescribed for them.

Twenty to thirty percent of the studies stressed how recovery was an individual and unique nonlinear process and journey. This highlights the need for care to be personalized and attuned to improvements as well as setbacks. Several other characteristics were mentioned less frequently (in 7–17% of the studies). These included recovery occurring *as stages* which poses the challenge of phase-specific care which would require identifying stages of recovery as well as what kind of care would be most helpful at each stage. While efforts in this direction may have some promise [37, 38], it is important to point out that personal recovery has also been described as being nonlinear in nature and that the transtheoretical model of behavioral change [39] on which such models are typically based is limited in its application to mental illness [40]. Rigid interpretations of this model can inadvertently lead to structures in which people are prevented from participating in potentially healing, recovery-based services based on a professional assessment that such participation is not "stage appropriate"—a practice that is not consistent with the spirit and intent of recovery-oriented care [40].

Recovery was also referred to as a struggle, life-changing, multidimensional, and gradual process. These are important reminders not to confuse the greater optimism embedded in recovery with it often being extremely challenging and influencing several life domains which take time to recover from. Other mentioned characteristics were that recovery can occur without cure or professional intervention, at times by trial and error and often facilitated by supportive environments. These have important implications as it suggests that one can live a personally meaningful life even if still experiencing ongoing symptoms and that this process can be facilitated by supportive environments and various personal efforts and not necessarily as a result of services alone or at all. This calls for the need to broaden care systems and focus more on modifying environments and providing support for goal-setting and attainment that is not contingent on symptom remission.

Finally, the systematic review revealed five categories of *recovery processes* which were frequently mentioned: *c*onnectedness, *h*ope and optimism about the future, *i*dentity, *m*eaning in life, and *e*mpowerment (yielding the acronym CHIME). All of these processes can be viewed as basic human building blocks on which most people construct their lives and which might be particularly crucial at times of despair when coping with psychiatric symptoms. Given what is known about these processes, what implications does this have for the design and delivery of psychiatric care? Translation to practice will, of course, vary depending on personal preferences as well as social, organizational, and political-economic context. But in the following section, we offer representative strategies for professionals who are committed to the principles of recovery-oriented care but uncertain as to what this might look like in routine service settings.

Recovery-Oriented Practice

Whereas "recovery" is what the *individual* does to manage his or her condition and reclaim his or her life from the direct and indirect effects of the illness, r*ecovery-oriented care*, on the other hand, is what *health-care providers* offer in support of the person's own efforts to move forward and pursue a "a meaningful life in the community" [32]. Recovery is not something you can do "to" or "for" someone else. While recovery, much like learning, is the primary task of the individual, there is still much that caring others can do to facilitate this process through the actions of both formal (i.e., health-care providers) and informal (e.g., family, friends, employers) supporters. It is within this arena that we see the great potential of the recovery-oriented approach, which has increasingly been recognized as a powerful source of encouragement in recovery among persons living with serious mental illnesses [41].

Consistent with the five CHIME recovery processes identified above, recovery can be promoted at the individual level through the following:

Connectedness

> The biggest thing that is stirring all of this recovery for me is the love that I have in my life today.

Nurturing relationships that afford people a sense of belonging and self-worth is central in recovery. Connectedness is crucial yet not always easy to form due to illness-related factors such as impaired social cognition, environmental factors such as public stigma and lack of opportunities, as well as consequent personal ones such as loss of confidence and self-esteem. Nurturing connection can, and should, involve relationships both within and beyond the formal treatment system, that is, with both professionals and natural supporters. This is consistent with the view that recovery is not seen as a solitary process but rather as a journey toward interdependence with one's community of choice.

What representative strategies might this entail? In the context of inpatient care settings, this may begin by reflecting on the flow of the person through services and even on the environmental space occupied by carers and service users and the extent to which it enhances, versus hinders, opportunities for connection and authentic interactions. How are people greeted upon transfer to a psychiatric inpatient unit? Is someone available to give them a tour and orient them to the program, perhaps a peer specialist? Are they offered personal introductions to those with whom they will be expected to share their story and to whom they will be expected to entrust their care? Are there user-friendly orientation materials or postings that make clear each person's role, perhaps even including a picture of various staff and their roles or "go-to" areas of responsibility. Even the structural layout of the inpatient milieu can have a marked impact on the nature of connectedness in psychiatric care. Are there opportunities for fluid interactions throughout the day in an open setting, or do staff spend the vast majority of their time behind closed doors in off-unit offices or behind the plexiglass border of a centralized nursing station? These spatial layouts can be powerful reminders—both literally and figuratively—of the "us–them" divide that perpetuates distance, rather than promotes connection, between professionals and persons in recovery.

In the context of assessment and planning procedures, connection is also supported through thoughtful consideration of the strengths and resources beyond the formal treatment system, that is, within the individual's family, natural support network, and community at large. For example, at the person's discretion, he or she might extend an invitation to a natural supporter to participate directly in his or her person-centered care planning (PCCP) process [42]. As with any participant in person-centered planning, it is important for family members and other invitees to be oriented to the process so they can be effective members of the team and learn what might be helpful, versus not-so-helpful, ways of contributing.

For example, while a family member should be encouraged to share his or her concerns so that the team can collectively brainstorm strategies and solutions, family members may also need to be redirected if they approach the meeting as an opportunity to align with professionals and to apply undue pressure on the person in recovery around key treatment and life decisions. When the care planning process has uncovered key connections in the person's life and those individuals are willing and able to lend their time, energy, and enthusiasm to the person's recovery vision, then these contributions should be documented as action steps in the recovery plan alongside those services offered by professional providers. Doing so represents an important opportunity to help the person build or expand upon the natural network that can help sustain their recovery over time.

Hope

> Hope just started to flow all over me. I could just all of a sudden feel brand new. The recovery model helped me feel brand new again.

Second is the capacity of professionals to instill hope and optimism for the future. This includes such things as believing in the possibility of recovery, inspiring motivation to change, helping the person to reconnect with their dreams and aspirations, and offering exposure to peer supporters as a living embodiment of hope in recovery. Such exposure is critical in instilling hope not only among persons with mental illnesses but also in the professionals who serve them.

Take, for example, the often-encountered debate that arises in the process of setting goals and envisioning a more hopeful future in recovery within the context of person-centered care planning. Professionals may be hesitant to support an individual's expressed goal out of concern that it is somehow "unrealistic" and that offering such support might set someone up for failure and disappointment. Practitioners cannot predict the future and should not presume to do so. In fact, many people who currently work as peer staff within the mental health system report being told by practitioners early on in their recovery that they would never be able to return to work due to the severity of their illness. Such pronouncements are not only demoralizing but convey a sense of certainty that is simply not warranted by the available data.

When collaborating with service users to explore recovery goals, it is far more helpful for the practitioner to help the person in recovery to "think big" as this presents an opportunity to demonstrate faith and hope in their recovery process and to help them live beyond the legacy of low expectations that has, for too long, pervaded mental health systems. Outcomes for people with mental illnesses need to include the expectations and aspirations shared by all humans (e.g., living, working, learning, playing, and loving in one's chosen community), not just lower-order thresholds or standards commonly valued in the human service system (e.g., stability, adherence, satisfaction with services). High expectations should be the norm for all people and not reserved only for those who are judged by practitioners to have reached a certain stage of recovery.

Identity

> I can look the world in the eye today and I respect myself a lot more. I'm more daring to try new things and some of the things I've discovered are things I really like.

Closely linked to this is the third category of identity, which involves using a strengths-based approach to help the person overcome stigma and to develop and maintain a positive sense of identity apart from the illness or disability [1]. This can be particularly challenging when people are constantly confronted with persistent distressing symptoms as well as explicit and implicit stigmatizing messages and attitudes that are encountered both within, and beyond, the mental health system. When facing such circumstances, practitioners need to conceptualize one of their first steps as assisting the person to get back in touch with his or her previous interests, talents, and gifts, using a range of strategies to help the individual to discover him- or herself as a healthy person with a history, with a future, and with strengths and interests beyond their deficits or functional impairments.

This may start with the consistent use of respectful, non-stigmatizing language. At all times, *person-first* language should be used to acknowledge that the disability is not as important as the person's individuality and humanity, for example, "a person with schizophrenia" versus "a schizophrenic." Employing person-first language does not mean that a person's disability is hidden or seen as irrelevant; however, it also is not to be the sole focus of any description about that person and his or her care. To make it the sole focus is depersonalizing and derogatory. While strengths-based, person-first language has long been recognized as an expected standard in mental health service delivery, the translation of this standard to consistent use in day-to-day practice has proven a far more elusive goal.

Formal strengths-based assessment procedures may also be employed to help people reclaim their personhood in the face of ongoing difficulties associated with the experience of mental illness. In some cases, however, simply inquiring about strengths may not be enough to elicit information regarding resources and capabilities that can be built upon in the recovery planning process. Creativity in the dialogue and in how one frames questions may be needed to unlock buried sparks of interest. For example, you can express genuine curiosity by exploring the following types of questions. *If you could design the "perfect day," what would it look like? What was the best compliment you ever received?*

When you were younger, what did you dream of doing when you grew up and why? What are you most proud of in your life? What is the one thing you would not change about yourself?

Strengths uncovered in this assessment process should then be actively used in the cocreation of the individual's recovery plan. Focusing on strengths is a powerful engagement strategy that can help people to develop hope for the future and establish motivating recovery goals. For example, a woman with a love of animals who is struggling with social isolation might be motivated by regular walks to the dog park. A person with a love of books might be engaged by being asked to help organize materials in the agency library or consumer resource center. Or a patient about to transition to the community from an inpatient program may have as a part of his discharge plan not simply a prescription for meds and an appointment for follow-up at the local community mental health center but also a prearranged ride to Sunday services at his local house of worship if faith-based coping is a central part of his recovery. The essential point is that uncovering strengths is not sufficient in and of itself to generate a strengths-based, recovery-focused care plan. Rather, practitioners must think creatively about how best to actively use the individual's strengths and interests as a way to help her or him reclaim a positive sense of identity beyond the experience of illness.

While the adoption of a strengths-based approach is often thought of at the microlevel and how it plays out in a 1:1 treatment relationship, it has similarly cogent implications for changes in the structure and design of services across a range of psychiatric care settings. For example, there have been attempts to organize mental health services according to participants' primary psychiatric diagnoses or even based on their assessed level of functioning or degree of cognitive impairment. The rationale for such "tracks" in programming includes the ability to group participants according to level of need and to assign staff with specialized clinical and rehabilitative expertise. While there may be value to the person in recovery to interact with others with shared lived experiences and to receive more targeted programming and intervention, such structures should be pursued with certain cautions in mind as they can be used as a means of rigidly tracking people into one predetermined set of treatments and rigidly excluding them from others. Specialty tracks can easily take on a demoralizing tone (e.g., the specialty track for "low-functioning psychosis" is quickly recognized by both staff and patients alike), and they may leave little room for exposure to a wide range of recovery-based interventions while reinforcing the internalization of illness as one's primary identity.

Meaning

> It's an awakening to all that you could be doing, and in my case, the fact that life was worth living.

The fourth category is meaning in life, which includes finding meaning in illness experiences that would require valuing lived experience and encouraging curiosity- and meaning-making processes rather than simply accepting others' explanations for one's own difficulties. Consistent with Nietzsche's famous adage that "He who has a why to live for can bear almost any how," this calls attention to the opportunities and supports people need in order to create meaning in their lives. Traditional models of care do not necessarily view meaning as an important or valued goal and are not always designed to encourage or support such efforts. In contrast, a recovery-oriented system makes space for each person's own unique understanding of what has happened to him or her and how she or he make sense of these experiences, even when such conceptualization may challenge traditional notions of psychiatric illness.

For example, the Hearing Voices Network (HVN) [43], a peer-focused international community of persons with the lived experience of voice-hearing, has emerged as a platform to question how mental health treatment currently understands, categorizes, and responds to mental distress. Rather than seeing voices, visions, and extreme states as symptoms of an underlying illness, HVN members believe it is helpful to view them as meaningful experiences—even if we don't always yet know what that meaning is. This position has an important role to play in a recovery-oriented system of care as it aims to keep the service user in the driver's seat and encourages him or her to define his or her own experiences and how they should be managed.

For some individuals, this may translate into a process of shared decision-making in which a practitioner is open to alternative approaches beyond antipsychotic medication to help manage an individual's distress. In other cases, it may mean honoring that the person may not perceive the experience as a manifestation of psychiatric illness to begin with, may not find it to be that distressing, and may not choose to "manage" it at all as it may hold important meaning for them in their lives and their identities. In this sense, it respects that fact that people who have lived with what we refer to as "mental illness" have learned much in this process and are the foremost experts on their own lives and recovery. As such, they are in the best position to speak to the strengths and limitations of current treatment systems, and they should be actively involved in recovery transformation efforts at all levels [44].

Empowerment

> It used to be me coming to the mental health center expecting them to fix me. Now I can better manage my own care. I'm able to set goals for myself and go to new heights.

Finally, the last recovery dimension focuses on empowering people in recovery to exercise enhanced self-care and a range of fundamental rights including the rights to citizenship, social inclusion, and active participation in care planning. Similar to other categories, there is a great need to change what we have traditionally focused on to assure people have the chance to engage in these kinds of recovery processes.

Recovery-oriented care is based on the premise that mental illnesses can be managed through the concerted efforts of the person, his or her most significant supporters, and skilled and knowledgeable practitioners. This remains true even in the lives of those people who have been demoralized by a mental illness and the discrimination associated with these conditions. For such individuals, an early step in recovery-oriented care may then be to help the person and his or her loved ones to view the person as a capable agent in his or her own life who can learn how to exercise some degree of self-care. Doing so does not minimize the role that family and professionals can play but encourages the person to occupy a valuable, central role in his or her own life. Taken together, the focus in recovery-oriented care shifts from what the practitioner needs to do to treat the illness to what the person and his or her loved ones need to know how to do in order to exercise good management of the illness on an everyday basis.

Examples of specific strategies may include encouraging (but not mandating) the creation of a Wellness Recovery Action Plan (WRAP) which is a personalized recovery system born out of, and rooted in, the principle of self-determination [45]. WRAP helps people to utilize simple, safe, and effective strategies to more effectively respond to distressing symptoms and maintain their wellness on a day-to-day basis. Similarly, practitioners can promote empowerment by ensuring people have opportunities to write their own crisis and contingency plans. Often referred to as "psychiatric advanced directives," these plans provide detailed instructions regarding an individual's preferred interventions and responses in the event of a psychiatric crisis in which a person may be temporarily unable to speak for him- or herself. As such, they represent a promising tool to help a person maintain as much dignity and autonomy as possible at a time where practitioners may need to exert greater influence over treatment decisions.

Recovery-oriented self-management tools such as WRAP and psychiatric advance directives should actively inform a formal person-centered care plan (PCCP) within the person's individual medical record. As mentioned above, PCCP is a collaborative process in which service providers and people in recovery work together (sometimes 1:1 or sometimes in a team) to cocreate a plan that helps the individual achieve their most valued life goals [42]. PCCP rests on the premise that people are the experts on their own lives and experiences and, therefore, the professional plan of care should start with, and stay true to, what people have come to learn is helpful (or not) in the management of their own recovery.

If we take for a moment the analogy of recovery being a "journey" and the care plan being the "road map" to the hoped-for destination, then what we are trying to do in person-centered planning is to help the person get into the "driver's seat" of their care as much as possible. The approach of person-centered planning recognizes that the degree of participation and self-direction for each person is going to vary based on a number of factors, including individual and cultural preference, clinical status, communication abilities, confidence level, stage of change, skills and experiences, etc. In addition, the approach does not invalidate the clinical expertise of professional staff. Rather, it is a model based on *partnership* in which there is mutual respect between the person and his or her caregivers. The person seeking care is an autonomous individual who deserves respect, and the ultimate decision-making rests with this autonomous individual. However, the expertise of the practitioner is also recognized, and high regard is given to his or her professional opinion and experience.

This means that as professionals, we need to be willing to shift seats, become a copilot, and share power with the individual throughout the care planning process. Just as this involves a role shift and a competency shift for practitioners, the same may hold true for many persons in recovery who may not yet be comfortable being in the driver's seat. This is especially true when they have become accustomed to being viewed and treated as more of a "passenger" where their typical participation in the care plan may have been limited to the expectation that they sign it. In order to overcome these traditions, it is critical that mental health systems offer advance notice of planning meetings, as well as education in/preparation for PCCP (i.e., "driver's education"), so that people in recovery can gain the confidence and competence to actively partner in the PCCP process.

It is important to note, though, that as the concept of personal recovery has made its way across the globe, this core emphasis on self-determination has come to be called increasingly into question. Even within the US, persons from Hispanic and African American cultures have found such a narrow focus on the person, extracted as it were from out of his or her family and community context, to be culturally ***un***responsive. Similar critiques have been made from the perspective of Chinese culture [46, 47] and, more recently, from Indian culture [48] as well. For individuals who prefer to have others involved in their decision-making, practitioners are to honor these preferences as it would not be very "person-centered" to insist that people make their own decisions when their cultural preference would be to defer to the wisdom of family or elders [49].

As seen with other core recovery processes, what it means to promote empowerment must be considered at both the micro (i.e., individual treatment relationship) and the macro (i.e., organizational context and structures) levels. This requires an honest self-reflection on the range of coercive practices in mental health systems that strip people of their choice and autonomy rather than promoting their personal empowerment. For example, "clinical gatekeeping" (e.g., being denied access to a supported employment program based on a clinician's assessment that an individual is not "work ready," when such assessments have been shown to have limited predictive validity in vocational outcomes) has no place in a recovery-oriented system of care. In contrast, promoting empowerment means honoring a "no wrong door" approach that provides direct access to a diverse array of services to which individuals can self-refer without the need for referral or approval from a primary clinical provider.

Similarly, certain methods of behavioral programming, such as token economies or level systems often seen in inpatient or congregate residential settings, undermine empowerment by substituting an external locus of control for efforts to promote self-management and autonomy. Whether or not these methods effectively prepare someone for discharge and transition to a lower level of care also remains a point of contention in our field. What we do know is that while there is some evidence showing that problematic behaviors can be successfully shaped through the use of token economies in the inpatient or residential contexts, there is no token economy to follow the person into the community [50]. A person can learn to comply with an externally imposed structure while in the hospital, but in the absence of that structure, we would suggest that what is needed is effective self-management and wellness skills similar to what can be taught in such evidenced-based practices as WRAP or Illness Management and Recovery (IMR). In these models, the person is seen as an active partner in his or her own recovery rather than a passive recipient of care—something that is more consistent with a recovery orientation as well as the type of self-management we have seen for decades in the treatment of chronic medical illnesses such as diabetes. At the same time, systems of care need mechanisms in place to manage acute psychiatric issues that can lead to serious safety issues, as well as disruption of the healing environment for everyone. In this circumstance, a recovery-oriented approach might challenge practitioners to develop personalized safety plans or Positive Behavioral Support Plans to be proactive and responsive in addressing individualized needs rather than defaulting to a more coercive "one size fits all" behavioral program.

Conclusions

The concept of clinical, or full, recovery has been around since the birth of the discipline of psychiatry itself, yet it is questionable the degree to which this concept has informed the routine practice of mental health care in either inpatient or outpatient settings. Most programs, that is, have assumed a long-term or chronic care perspective and have done little to inspire hope for a full recovery, which admittedly may require a longer period of time than most programs allow. Meanwhile, the concept of personal recovery has now been around for roughly 30 years and has stimulated the rapid development and expansion of self-help/mutual support and peer support approaches, both outside and inside of mental health systems. Aside from the impact of these new alternative or complementary supports—and despite the global proliferation of government mandates and policy statements endorsing recovery as an overarching vision for mental health care—a broader and deeper transformation of routine clinical practice remains largely a task for the future.

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