9 The Recovery Model and Modern Psychiatric Care: Conceptual Perspective, Critical Approach and Practical Application

Stelios Stylianidis, Michail Lavdas, Kalomira Markou, and Pepi Belekou

Abstract

The recovery model is a model that allows an individual to take back control of his life. It was primarily developed for serious mental disorders for which the biomedical model precluded any possibility of "real recovery" and control over life by individuals with mental disability. From a biopsychosocial viewpoint, the recovery model shifts the treatment objective from reducing symptoms to real integration and assignment of meaning of the life of individuals and their participation on equal terms in society. In other words, the perception is that recovery-as-healing goes beyond the concept of "therapeutic accompaniment" and "care", as formulated by Racamier (Le psychanalyste sans divan. La psychanalyse et les institutions de soins psychiatriques. Payot, Paris, 1970, Les schizophrènes. Payot, Paris, 1980, Le génie des origines: psychanalyse et psychoses. Payot, Paris, 1992), and is transferred into modern psychotherapeutic concerns about psychoses. In any event, that requires a change in culture and how psychiatry is practised. In other words, it requires the individual to function as a user of mental health services, as an "expert user" when it comes to his own illness and not as a passive user who complies with treatment guidelines. This change must be accompanied by a simultaneous change in the way services are structured and operate, and in the more general attitude of the community, so as to accept difference and to make individuals adjust to the "norm" of a condition for integration.

S. Stylianidis (✉)
Department of Psychology, Panteion University, Athens, Greece
e-mail: stylianidis.st@gmail.com

M. Lavdas • K. Markou • P. Belekou
Association for Regional Development and Mental Health, Athens, Greece
e-mail: p.belecou@hotmail.com

S. Stylianidis (ed.), *Social and Community Psychiatry: Towards a Critical, Patient-Oriented Approach*, DOI 10.1007/978-3-319-28616-7_9

This chapter explores the history and conceptual meaning of the recovery model and ends with critical remarks about how it has been applied at both Greek and international level. This path is accompanied by presentation of a clinical case to show how the recovery model can be used in practice.

9.1 Introduction

The concept and practice of *recovery* appears to have been gaining ground over the last decade, particularly in the best practices of Anglo-Saxon countries and the experiences of deinstitutionalisation and critical psychiatry in Europe.

The plethora of references in the literature to the concept of recovery and the different perspectives of those involved in psychiatric care and psychosocial rehabilitation (mental health professionals, families, users of services, volunteers, managers of mental health services) have frequently caused confusion and a sense of fluidity about the real meaning of recovery and how it can be applied in practice.

This chapter attempts to clarify the conceptual confusion which exists about recovery and how it has been perceived in Greece. Moreover, a systematic literature review enables us to comment on objections to its adoption in practice by looking at clinical examples, in the context of psychosocial rehabilitation at the Regional Development and Mental Health Association.

9.2 Conceptual Framework and Definitions of Recovery

Laird (2002) proposes four different definitions for recovery: (a) returning to a normal state; (b) an act, instant, process or period of recovering; (c) something gained or restored in the process of recovering; and (d) an act of acquiring useful substances from untreated sources, such as scrap.

These four definitions (Davidson et al. 2005) can be used to clearly and accurately identify four different categories in the context of holistic healthcare such as (a) acute physical conditions, (b) injury and its consequences, (c) disorders caused by substance usage and (d) serious mental disorder.

Babiniotis (2002) defines the Greek word for "recovery" (*anarrosis*) as "the gradual rehabilitation of health after an illness" which is similar to the definition [a] in the Webster dictionary which relates to physical health, even if chronic such as asthma, diabetes, cancer etc. Likewise, Babiniotis (2002, p. 767) tells us that the Greek word *iasis* (healing) makes a "rehabilitation of health".

We can see that the concept of rehabilitation appears in both the definitions of the Greek words for *recovery* and *healing*, but this cannot fully capture the fourth definition of recovery contained in the Webster dictionary. However, given the wider heterogeneity of serious mental illnesses both in terms of diagnosis and treatment, recovery is seen as having different meanings for people who have experienced or are experiencing different developments and outcomes for their illness.

Despite the lack of uniformity, most definitions of recovery include the elements of acceptance of the illness, hope for the future and the search for renewable self-meaning and a different identity. Three of the most frequently citied definitions of recovery in the literature are provided below:

1. Recovery presupposes the development of new meaning and life purpose for an individual, as he grows beyond the destructive results of psychiatric disability (Anthony 1993).
2. Recovery relates to the actual life experience of individuals who accept and move beyond the challenge their disability poses (Deegan 1988).
3. Recovery is a process via which individuals with psychiatric disabilities can rebuild and develop important personal, environmental, social and spiritual ties and come to terms with the destructive effects of discrimination by integrating them (Spaniol and Koehler 1994).

Definitions of this type, which clearly converge and complement each other, differ from the definition used in clinical research. In that perspective, recovery is defined as the disappearance of the symptoms which caused the individual disability or, in the case of physical health, a return to the previous state (Young and Ensing 1999). Consequently, *recovery* in clinical research is the absence of some unwanted points or situations, such as illness or symptoms, or the disappearance of some problem that was not part of the individual's life before the illness, by using medication or hospitalisation (White 2000; Whitwell 2001).

Although this model can include positive improvement indicators, such as work and home, the focus nonetheless remains on overcoming barriers and on a return to the previous state of health (Davidson and Strauss 1995).

From the viewpoint of users of mental health services and professionals involved in psychosocial rehabilitation, recovery cannot be viewed as a "static situation or result" (Deegan 1996a, b) nor is it the same as treatment; instead it is a life process which involves an increasing number of steps towards different life levels (Jacobson and Curtis 2000). The outcome of all this is that recovery, in Greece, has begun to be experienced by the movement of users of mental health services and their families more as an attitude, a way of life, a feeling, a vision or experience (Deegan 1988, 1996a, b), rather than as a type of clinical outcome per se.

Restoring the state prior to illness is a one-dimensional view of one's overall self-meaning, which is capable of forming an identity and of attempting to achieve goals which have meaning for oneself, rather than merely the persistent, frequently tortuous existence of the results and side effects of mental illness (Davidson 2003; Davidson and Strauss 1992).

Combining the bibliographical references together, we suggest that *recovery*, for the purposes of Greece, be seen as a continuous process of getting better that leads to healing or in short "recovery-as-healing".

9.3 Concerns About Recovery-as-Healing and the Biomedical Model

The focus of the process of recovering from an illness includes, among other things, the idea of the individual reacquiring habits and a life plan, which can be used to define his personal identity day by day.

The aim of recovery, which does not include "healing here and now" as a goal of the doctor-patient therapeutic relationship, presupposes a shift in attention from the illness and its development factors to what is really in question: reinvestment in an active life, improving to the maximum degree possible for the individual his day-to-day conditions and social life. That presupposes that we rely on those "unused resources" that allow us to overcome the consequences of illness, to highlight our personal goals, and the role of faith or hope that a recovery/healing is possible.

This approach presupposes conscious "disconnection" of the history of the illness and the factors that affect it from the individual's past, which also includes a series of other definitive factors (Bowie et al. 2010). The perception is that recovery-as-healing goes beyond the concept of "therapeutic accompaniment" and "care", as formulated by Racamier (1980), in contradistinction to the one-sided view of treatment which has been transferred into the modern concerns of the psychotherapy of psychoses (Mentzos 2008; Benedetti 1992; Hochman 1986; Rosenfeld 1965; Searles 1965; Vartzopoulos and Stylianidis 2008).

Personal initiative and the individual assigning meaning in the recovery-as-healing process, developing or redefining a life plan (Sartre 1985), which was brutally interrupted by the onset of a serious psychiatric disorder, is a modern development and transformation of the substance of deinstitutionalisation, as formulated by F. Basaglia and the Italian Psichiatria Democratica (Basaglia 2005) movement. This disconnection of illness from the individual's life plan also includes other factors. Psychopathological factors are not adequate to interpret the phenomenon of day-to-day life being temporalised, increased barriers to full psychosocial rehabilitation and more so the future and personal life of the individual (Gerard 2011; Pachoud 2012; Warner 2004).

Even the disconnection of the clinical approach and holistic outcome for the individual is not widely recognised in the international scientific community and literature, but it is "familiar" to many clinicians. Take, for example, the many patients with serious psychiatric disorders who present no symptoms after effective treatment using psychotropic drugs but face immense difficulties in finding an active social and personal life again. In any event, the so-called negative symptoms of schizophrenia are a critical enigma and challenge in clinical psychopharmacology. On the other hand, we have those patients who despite the chronic presence of productive psychotic symptoms, such as delusions (audio, visual, sensory etc.), manage to achieve a stable life and relative autonomy, with social ties and a job, and participate in a process of persons improvement of their cognitive and social skills (Liberman et al. 2002, 2008).

Recognising and accepting this "mismatch" between the biomedical model and the process of recovery/integration/healing necessarily leads us to adopt two

discrete strategies which must operate as a complement to each other, to promote the holistic approach to patients' needs: in addition to the traditional medical strategy which aims to address the symptoms of the disease and maximise the potential for a positive outcome, it is also necessary to implement a strategy of equal importance that supplements one's clinical practice and which methodically aims at maximising the individuals' potential for recovery/healing/social integration. A key role in the recovery strategy is held by life experience, testimony and narratives, which in terms of qualitative research have the same important scientific value as epidemiological studies about the prevalence and outcome of schizophrenia.

The study and practical implementation of projects in this direction, such as the very important synthesis done by Amering and Schmolke (2009), highlight important aspects of the recovery process, such as empowerment and the ability to choose, or the role of self-determination, hope and in particular narrative ability and reformulation of the subject's identity (Giddens 2004). Narration and the creation of a framework for highlighting and listening are for certain writers the preferred way of describing human experience and changing the individual's perspective and stance towards the prospect for re-establishing his identity and life plan, while minimising the consequences of mental disability (Davidson 2003).

This interpretation of the stories of users of services and the perception of mental health professionals about recovery and psychosocial rehabilitation can give us the opportunity to improve the qualitative methodology and document the implementation of recovery plans in a mental health service (Greacen and Jouet 2012).

9.4 Modern Developments in Recovery

Recovery from a mental illness, as narrated by Pat Deegan through her description of her psychotic experience, is a process of personal development and growth, a way of life (Deegan 1988, Deegan 1996a, b) and not a return to the situation prior to the illness. Such testimony from other individuals who have experienced a serious mental illness and long-term studies over the last three decades opened the way for further research and applications in the field of recovery, demonstrating that individuals who suffer from schizophrenia can recover and enjoy positive results in a life full of meaning (Anthony et al. 2003).

The findings of research show good long-term results for the majority of people with serious psychiatric disorders. The best known research is by Harding et al. (1987) which monitored a group of 269 individuals who on average had 10 years of absolute disability and 6 years of continuous hospitalisation. Those individuals participated in a dynamic psychosocial rehabilitation programme, completed it and then received community mental health services. The results from the 10-year follow-up showed that although 2/3 of the group lived in the community, they were utterly dependent on services and were socially isolated, which was not particularly encouraging. However, the second follow-up at 20–25 years showed that around 55 % of the individuals had regained functionality to a significant degree, did not have problems or had very few problems and had recovered. At the same time, a

study carried out globally by the WHO into schizophrenia (Harrison et al. 2001) followed up individuals diagnosed with schizophrenia in numerous countries after a 15- and 25-year gap. The results show that 56–60 % of those individuals had recovered.

After these developments, interest began to grow in the recovery model as a re-exploration of psychiatric care and its practices (Roberts and Wolfson 2004). Major attempts to implement the recovery model have been made around the world in the mental health sector, showing a clear trend of moving away from traditional, biomedical models. Some US states, New Zealand, Australia and more recently European countries, like England, have begun to plan and develop mental health services focused on the recovery model. In the USA, for example, the recovery model was adopted as the central policy on mental health in 2003, as part of the reform of the mental health system. We also have the example of states like Massachusetts, Florida and Ohio which designed and developed recovery model-based services. Likewise, in 2001 New Zealand and England integrated the concept of recovery as central to the planning of mental health services.

Even though some of those services at first sight have not familiarised themselves with these concepts, and may appear to be services provided in a traditional setting by many mental health systems, there is no such thing as a recovery-oriented service whose central idea is not that recovery is possible and whose goals are to foster hope, healing, empowerment and connection.

Since the experience of recovery from a mental illness is essentially personal and individualised, and is something much wider than the remission of symptoms, we see a constant need on the part of researchers to develop research tools to respond to the sheer breadth of definitions of recovery. Despite that, the methodology of traditional documented research cannot respond and evaluate new practices – methods for developing mental health services, like recovery (Anthony 2000). Most researchers stress that qualitative methods will play an important role, making it clear what the recovery process includes in order to achieve the transformation of mental health services in that direction.

Personal narratives are particularly valuable here. Individuals narrate their stories explaining their personal journey over the course of their recovery and talk about what has helped them. Those narratives, and the internal dynamic they have, open the path to demystifying mental illness, demonstrating a dynamic path towards achieving goals (MHC 2005).

The perceptions of mental health professionals and the culture of organisations that provide services are very important factors since one needs to create such environments or systems that favour the recovery process. The literature identifies recovery-oriented services as those within which individuals are supported as they grow and implement their personal recovery plans, which can encourage their personal preferences and allow the user of services to assume risks and move forward (Weaver 1998).

In the systems providing mental health services referred to, employees are trained in the principles of the recovery model to achieve two objectives: to explore the concept of recovery and at the same time to explore the role of the mental health

professional in this case. In addition, these systems integrate services provided by mental health professionals, services provided by service users and services provided by a combination of the two.

9.5 Case Study: Implementation of the Recovery Method

Case

A.G. is 50 years old and suffers from organic psychotic disorder. The problem presented at the age of 35 following excessive alcohol consumption. He presented symptoms of aggression, mainly verbal aggression, persecution complex, suspiciousness and lack of trust in all around him. He has finished junior high school and completed his military service, has worked and has been married. When the problem started he separated, was left homeless and was treated at Dafni Psychiatric Hospital where he received medication. He did not follow medical guidelines and his situation deteriorated. After his last period of treatment at Dafni, he was transferred to the Paleo Penteli Residential Unit at the age of 47.

Problems the resident faced:

- Alcohol addiction
- No insurance coverage (for health insurance)
- No financial support (no job and no benefits)
- No family support
- No social contact with friends
- No love life

Treatment plan for the recovery process and to improve the quality of life

- Take medication and stop alcohol consumption
- Obtain a health insurance booklet and welfare benefits
- Pscyhoeducation
- Re-connect with family
- Social skills training
- Work
- Sheltered accommodation

A.G. is 50 years old, comes from Athens and suffers from organic psychotic disorder. According to his own testimony, the problem presented at the age of 35, at a time when he was consuming excessive quantities of alcohol to escape difficult situations in his day-to-day life. When he drank, he would have symptoms of aggression, mainly verbal aggression towards parents, friends or unknown people, whom he would shout at and pester. Often his outbursts of "anger" (as he called it) would

be accompanied by ideas of suspicion, persecution or lack of trust. He had finished junior high school and done his military service and when he came back after the army went to an iron and aluminium design school. His training helped him work as an ironsmith sometimes in private companies and sometimes in his family's business, alongside his brother. At the age of 33, he married a foreign woman from Sri Lanka and stayed with her for 6 years. However, when A.G. began to cause problems due to his drinking, his wife was forced to leave because she could not stand a life like that. However, they continued in law to be married since they had not divorced, because his former wife needed him to renew her visa and residence permit in the country.

After they separated, he returned to his family home where he lived with his brother and mother. His father had died a year earlier, when A.G. was 37. Cohabitation was not an easy affair at all. He continued to drink and stopped working, and his brother was forced to seek a Public Prosecutor's order to have him admitted to the Dromokaitio Psychiatric Hospital. He stayed there a few days, was given medication and returned home. When leaving the hospital, he asked his family for money to go and live on his own, since he would cause problems if he continued to live with them. He did in fact rent an apartment, but did not keep up with his obligations (he didn't pay the rent or bills), and the owner evicted him. Since he had no other choice, he returned to his family home again. However, because of the incidents he caused, this time the neighbours obtained a Public Prosecutor's order and he was taken to the Athens Psychiatric Hospital at Dafni. Once again the doctors administered medication but he did not take it.

When he was discharged, he did not return home. He remained homeless and made a small shelter under the stairs of a church so he could sleep. He stayed there for around 2 years and was cared for and supported by women from the neighbourhood, who gave him food and money which enabled him to buy cigarettes and drink. He enjoyed that period because he felt free to do what he wanted and did not have to give account to anyone, especially not his family. After much discussion and exhortation from others, he decided to voluntarily admit himself to hospital so be able to be transferred to some psychosocial rehabilitation unit. In April 2009, he was transferred to the Palia Penteli residential unit; the scientific treatment team there came into contact with the hospital, his family and residents of the area where he lived to collect information, and this played a vital role in designing his individual treatment plan and implementing the recovery model.

When collecting all the information about his story, the team initially recorded his problems, invited him to tell them why he had been transferred to the residential unit and attempted to understand from the discussion whether he accepted that he was suffering from a serious mental illness and needed help. A.G. accepted that he had had a bad time and that all the negative things in his life had started from the time he started drinking. He wanted to lay a new foundation and start over afresh, which would allow him to acquire a normal, decent life. His "acceptance" of the problem was the springboard for starting the treatment process.

Relying on the basic principles of the recovery-as-healing model (the recovery model) which preach a renewal of hope and decisiveness, regaining of social

position, managing symptoms, overcoming stigma and redefining oneself, the team explained to A.G. that the path to recovery is a constant struggle which goes through various stages before the goal is reached. In those stages of recovery, mental health professionals are there to help and guide. They offer hope and the belief that recovery can happen; they train, support, inform and design the individual treatment plan and focused on a structured programme that helps the individual improve his quality of life in the community.

Taking into account the user of services' problems, the team set a series of priorities and started from the easiest and most achievable, which would bolster self-confidence and provide satisfaction and the hope that the objective could be achieved. For example, A.G.:

Was addicted to alcohol and was not taking medication
Did not have social security (to cover medical treatment)
Did not have financial support (or a job or benefits)
Did not have family support
Did not have social contacts

The team's primary, main goal was to administer medication and get A.G. off alcohol, and it proposed that he attend a detox programme and enrol with Alcoholics Anonymous. He did not agree, insisting that he could manage on his own and that he should stay at the residential unit. The initial period was not at all easy. He found it difficult to sleep, had headaches, asked for painkillers to calm down and did not participate in outings to avoid contact with places selling food and drinks since he feared he would only be incited to drink. Every week he met with his psychiatrist, and every day the scientific team talked with him and supported him as he continued his efforts. It took about 6 months for him to come off alcohol, and during that entire period, he received medication which he now continues.

He had no insurance coverage as mentioned. He did not appear to be registered with any social security provider and that created problems because he had no Medicare. Since he did not have access to public services, while he was receiving training, the scientific team told him about his rights, and with the help of a social worker, he collected together all the paperwork needed and submitted it to the welfare department to get a welfare book and a welfare allowance. The allowance was a small amount of financial aid, since at that time he did not have any financial resources, other than the small amount of help he continued to receive from the Church.

Seeing that he could resolve important practical issues, he began to trust himself, to have hope and have an incentive to continue his attempts to regain a normal life. Once he was able to recognise reality and set realistic goals, he started psychoeducation. The purpose was to use face-to-face sessions with his psychologist to be able to understand the situation he was in before the treatment; to place emphasis on the continuity of care by continuing his medication, which was vital; and also to evaluate his needs, interests and wishes, so that he could continue to improve his quality of life.

The next step was to reconnect with his family, who had pulled away and did not want any contact with him because it could not manage the problems his behaviour created. When he entered the residential unit, his brother was quite distrustful and appeared disappointed and considered that nothing would change, since this was a tried and tested pattern of behaviour. The scientific team advised him to give A.G. time, to visit him with their mother more frequently at the residential unit and to have a positive outlook on the efforts A.G. was making, because this time he was inside a structured framework now. A.G. received indirect support from the family visits, tried harder and believed that he could regain their acceptance. In fact, their relations today are back to normal and A.G. visits his family at regular intervals, wants to help his brother and takes care of his mother. His circle still cannot believe the change: it's as if they are seeing another person.

A.G. lacked much in terms of social contacts and social skills. As an individual, during his early days at the residential unit, we noticed that he was quite shut off and solitary and found it difficult to speak, and there were days he only wanted to sleep and the expression on his face was melancholic, as if something was missing. By giving him time to adjust and by talking to him and ensuring he attended a social skills training course, he managed to acquire friends, to go out, to attend social events, to be more communicative and to be expressive. Having been able to work in his past life (and having given that up because of drinking), we discussed with him how interested he would be in working again. He thought that would be impossible because of his medication, but it was something he wanted a lot. It was explained what the role of social partnerships is, and he became a member and for a year now has been working in a cleaning team at the Ministry of Labour.

Having taken quite a few steps, only the last, most difficult one remained: the preparations for him to be able to become autonomous and live in the community, either with a foster family or in sheltered accommodation. One year before this happened, with the help of staff, he began his training for living on his own and became involved in all the relevant aspects of such a life (e.g. personal hygiene, maintaining and cleaning his own space and communal areas, preparing meals, using public transport and social services to deal with issues that arose etc.). Since last June, A.G. has been living in sheltered accommodation with two roommates.

His own active involvement in planning his treatment, based on teamwork and cooperation, and his incentive to change and rehabilitate himself, brought about the desired result and one can talk of recovery here. According to Anthony (1993), "recovery can be described as a deep personal process unique to the individual, during which perceptions, values, emotions, goals, abilities and/or roles change. It is a way of living a satisfactory, hope-filled, contribution-packed life even given the constraints the illness imposes. Recovery includes developing new meaning and life purpose, as the individual grows beyond the destructive consequences of the mental disorder".

Having said that, the positive outcome for this user of mental health services entails several difficulties in implementing the recovery model. In addition to his disappointment and withdrawal when did not manage to reach a target, which is something the scientific team could deal with, there were serious issues faced by

staff. Since they did not have the necessary knowledge and training, they were distrustful about whether he could recover and considered that he would not achieve anything and clearly expressed this sense of pessimism.

In this case the head of the unit and scientific team had a dual role to play. On the one hand, he had to encourage A.G. when he lost faith, and on the other, he had to provide on-the-job training about the principles of the recovery model and our role as mental health professionals. Of course it was only to be expected that this would happen, and the employees were not directly responsible. The root of the problem lies in the public mental health system which does not ensure that people are recruited to these services based on specific criteria, nor does it ensure they receive continuing training, meaning that they have erroneous perceptions, they have no hope and their stigma about mental patients remains undiminished.

One should remember that individuals with mental problems may have special characteristics and resistances to change, which are frequently viewed by the biomedical model as irreversible and which in quite a few cases are not even taken into consideration. The fact is that such individuals continue to have abilities and skills to relearn things and to adjust to the circumstances of their life plan. It is not the diagnosis which defines the needs of the individual but the description of his needs, functionality and the constraints the illness imposes.

9.6 The Recovery Model and Its Relationship to Public Mental Health in Greece: Final Remarks

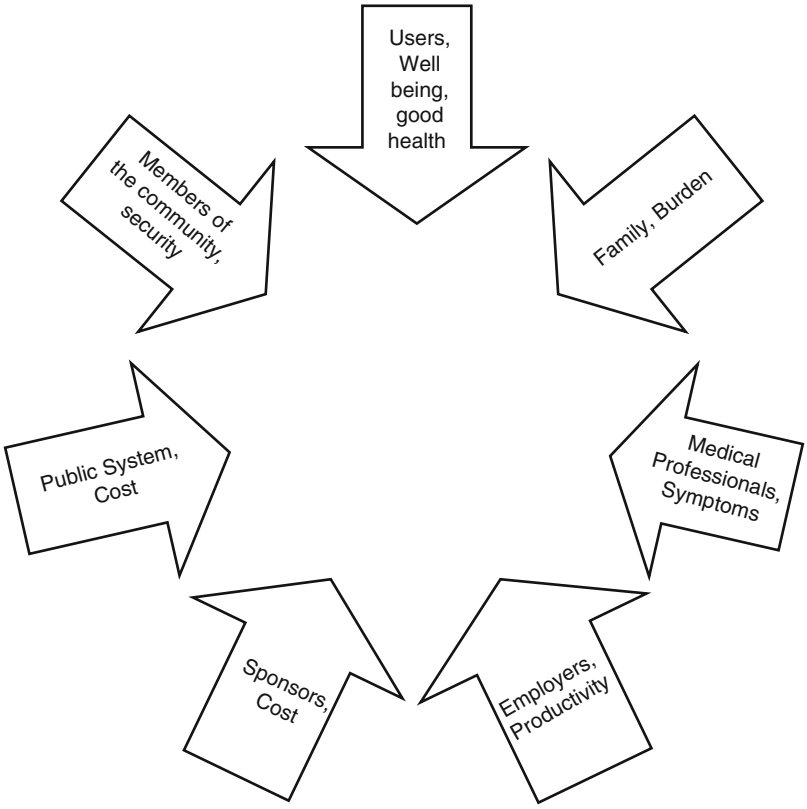
Implementing the recovery model as described above is a goal officially set out in the report of the working group on revision of the PSYCHARGOS programme (Ministry of Health and Social Solidarity 2012). The section referring to the structure of mental health care units and the functions of the overall mental health system, in terms of service provision, highlights the importance of promoting the recovery of patients and restoring them to their social roles and of social (re-)integration (p. 94). It is also included as one of the three main planks of education and training. In conjunction with key issues in social psychiatry and quality of care in mental health services and best practices for mental health promotion and education in the community, the aim of education must be to "firmly establish reform in the mental health sector, by disseminating cutting-edge examples of best practices in vital sectors relating to the organisation of services and their adoption by employees in the mental health sector" (p. 223). This is the PSYCHARGOS III Report and was approved by Ministerial Decision No. Υ5β/Γ.Π./οικ 46769 as the National Action Plan and sets out a series of actions over a 10-year horizon which seek to gradually address all needs in the mental health sector at the national level. The Ministerial Decision states it is "the operational arm of the Greek State's policy on psychiatric reform, deinstitutionalisation and modernisation of the system for providing mental health services".

Key aspects of deinstitutionalisation and real psychiatric reform are changes in culture about how psychiatric care is provided. Four different approaches are needed

here (a) in the culture of care which must provide assistance and protection, but frequently limits the autonomy of the patient; (b) the culture of care which places trust in experts and requires "compliance" (not negotiation) by patients in the context of the biomedical model; (c) in the culture of education which uses training methods to achieve goals in a friendly, structured manner; and (d) in the culture of empowerment which favours the transfer of power from experts to users of mental health services, creating a balanced relationship which seeks to safeguard resources and the environment, which are vital elements for the autonomous growth and development of users of services. The recovery model demands this shift in power and the commitment from the user of services to treatment via a process of negotiation and joint decision-making. This process is the opposite of compliance, which is defined as one-sided obeisance of medical orders and is a doubtful treatment goal since it does not appear to take into account concepts such as empathy and building up the importance of treatment (Molodynski et al. 2010). The special features of each user of services and the fact that his personality is taken into account are equally important factors as the skills and experience of doctors. Unfortunately, in Greece there have been shortfalls in and objections to adopting a culture which promotes real recovery, since the system has a lack of coordination, services are unequally deployed, there are insufficient links between services and services cannot network, all of which have negative repercussions on the continuity of care and all of which are coupled with the lack of any increase in financing which would ensure the viability of the system (Ministry of Health and Social Solidarity 2010). The structural problems which external evaluation identified in the period 2000–2009 also compound the difficulties in implementing the recovery model. More specifically, the involvement of users of services and advocacy was found to be underdeveloped, and there were major inadequacies in the destigmatisation of mental illness.

The inflexibility of the public system and its inability to support the culture of empowerment and recovery became particularly clear during the ongoing evaluation for the 2010–2015 period (Ministry of Health and Social Solidarity 2013) during which the scientific team from the Institute of Psychiatry found major problems in how the mental health system is organised and noted that the organisational structure has not improved in real terms compared to the findings of the ex-post evaluation (2010) which were presented above. It stated that "the system remains highly fragmented and without coordination, without linkages between the agencies and organisations involved. Users of services do not receive services in the context of the Mental Health Region in which they live, meaning valuable human and economic resources are not used rationally or efficiently". The picture of the public system in decline under current socioeconomic conditions (Kentikelenis et al. 2011; Stylianidis and Chondros 2011) is supplemented by the lack of participation by users of services since "users continue not to be involved in decision-making, in the control of units and on sectoral mental health committees". In addition, the high number of involuntary admissions to hospitals noted by the external evaluation and confirmed by Drakonaki et al. (2012) shows a major shortfall both in relation to the rights of persons with mental problems and the real implementation of the culture of empowerment and recovery.

In conclusion, using the recovery model, one does not just recover from mental health problems but also manages the fact that one has lived in a psychiatric institution and endured the consequences of the stigma of mental illness and isolation from society and work. However, the chronicity does not only lie in cases of long-term hospitalisation in an institution but also in cases of "institutionalised day-to-day life", with its painful repetitiveness. A key principle of the recovery model is that the chronicity of illness does not also mean that the situation has to be incurable, which is a prejudice a significant portion of mental health experts have, not just experts but all those directly or indirectly involved in or called upon to shape the "common language" which will create the conditions for implementing the recovery model, free of personal expectations which prevent recovery. We have identified a jigsaw of opposing views and expectations which is presented in diagram form below.



Consequently, the development of a common language between users of mental health services and mental health professionals is vital so that everyone can realise that mental health concerns us all, as the WHO recommends, and for each partner to shift his view of treatment from discouraging pessimism towards reasonable optimism of creative risk and change.

9.7 Uses and Abuses of the Term *Recovery* (Slade et al. 2014)

Abuse 1. Recovery Is the Most Cutting-Edge Model Around

Constant dissemination of the recovery model and recovery-oriented services means the risk of fragmentary changes in the structure and function of an organisation without that entailing a change in the culture, which is essential, is common. For example, 13 of the US states have committed to hiring users of mental health services via a national security system. Placing individuals with mental health problems in paid jobs is in line with the principles of the recovery model but does not mean on its own that it is sufficient. They may be hired but they are subsequently marginalised by colleagues, and the duties they are assigned to do not match their skills or are the minimum ones possible. In this way, empowerment through work operates independently of recovery objectives and does not promote equal participation, more hope and self-determination while also transforming culture.

Abuse 2. Recovery Isn't Applicable to "My Patients"

The ideology of recovery and the practice of achieving it have primarily developed through clinical work with psychosis. However, a major portion of mental health professionals declare that the model isn't suited to their own patients who they considered to be "too ill" to respond or unfit for recovery due to a diagnosis that doesn't match psychosis.

However, the recovery model has shown that it can be directly applicable even for individuals in crisis, while the literature also shows that the model can be applied to individuals who are not suffering from mental problems in the psychosis category, such as personality disorders and eating disorders, and to individual of different ages and nationalities.

Abuse 3. Services Can Help Individuals Recover Through Effective Treatment

Mental health professionals are more used to the clinical interpretation of recovery which relates to recovery from the symptoms of an illness and to the "clinical treatment" of an individual. However, the main meaning of recovery is to regain control of one's life – which anyone can do – and to give meaning to the roles one performs.

These two approaches (the clinical and the more personalised) may be complementary but one may experience one independently of the other. Traditionally, mental health services either supported the clinical aspect of recovery or (in the worst

case scenario) adopted the belief that recovery of any form is not possible for individuals with mental health problems.

To fully support the real sense of recovery, services and the mental health system need to break away from the dominant biomedical model, which entails medication and "compliance", even if administered without the patient's volition. Mental health services must constantly invest in hope in individuals, helping them define themselves, secure access to the entire range of social services (accommodation, education, work, self-help, crisis support and support in day-to-day life, psychological treatments and advocacy), improve their social integration and protect their human rights. Consequently, the treatment method can improve the personal growth of the person in recovery but impede attempts to achieve self-determination if tied into forced compliance practices.

Abuse 4. Forced Detention and Treatment Promote Recovery

Forced treatment is proposed as an effective way of dealing with an individual who cannot take care of himself. The idea of a Community Treatment Order was introduced in England in 2008, to reduce the number of involuntary admissions to the psychiatric department, but it has not had the expected results and in fact the number of committals has increased from 2007/2008 to 2011/2012 (44,094 in 2007/2008 to 48,631 in 2011/2012). The issue of a Community Treatment Order entailing forced treatment or committal was proposed as a less restrictive alternative solution that forced psychiatric treatment in an institution or psychiatric department of a general hospital. Despite the ethical, moral and legal problems of limiting the individual's freedom in the community, the idea has come to prevail in Anglo-Saxon countries that the key advantages of this solution, such as secured living for chronic patients in the community, a reduction in the "revolving door" phenomenon and the multiplication of patient's skills through social integration, could offset the disadvantages (Lawton-Smith et al. 2008; Monahan 2011). However, Stylianidis et al. (2013) have raised questions about the measure, criticising it for the following reasons: (a) lack of persuasive documentation, (b) a risk of increased use of coercive measures during the practice of psychiatry, (c) unresolved ethical and moral aspects of the entire procedure for the time being and (d) the potential to limit other alternative social care solutions.

A systematic review of the literature on Community Treatment Orders (Kisely et al. 2005) shows that there is little support for its effectiveness in terms of the use of health services, social functionality, the state of mental health, quality of life and satisfaction with care. Researchers have also shown that 85 Community Treatment Orders have prevented one readmission, 27 have prevented one individual from remaining homeless due to mental illness and 238 have prevented one arrest.

Community Treatment Orders appear to be becoming more common even though recent studies show that it is ineffective in preventing readmission (Burns

et al. 2013). In addition, Community Treatment Orders work counter to the process of regaining a life with meaning, a process which requires self-determination and respect for the individuality of the person as a citizen in society.

Abuse 5. Focusing on Recovery Means That Services Need to Close

Focusing on the recovery model is certainly not an adequate excuse for making cutbacks. It's not reasonable for one to assume that a meaningful life for an individual is not one lived within the narrow confines of a mental health service, and the view is frequently expressed towards users of mental health services that their contact with services unrelated to mental health and with informal forms of care is more important. The gradual reduction in contact with official mental health services and the transfer of support to informal support-in-the-community networks (friendships, self-help groups, community groups, work etc.) could possibly bolster the recovery process.

However, that process is not linear and services must be available for whenever they are needed again. The continuity of care means that someone may move from an informal type of care to a more specialised one and vice versa. The doors of communication must remain open to ensure continuous support for the individual, who depending on his state of health and life circumstances may choose a different form of support.

Clearly, ineffective services must be replaced or must adapt to the needs of users of services via a continuous process of evaluation and monitoring, in which beneficiaries themselves must be involved. A reduction in services is not justified under any circumstances by a focus on recovery, which requires constant support for individuals in the process of regaining control of their life using different services depending on their needs.

Abuse 6. Recovery Means Making People Independent and "Normal"

The clinical aspect of mental health services that offer services to integrate people into society primarily identifies problems those individuals have. Consequently, clinical interventions seek to bring about changes through treatment so that they can "fit in" and function "as normal" and "independent" individuals in the community. However, recovery does not simply mean "getting better" or no longer needing support. It means "regaining control of one's life" and the right to participate in all cultural and economic activities as a subject of law and equal citizen. It requires a system for providing services to be organised that is based on the principles of human rights and the social model for addressing exclusion. Integration and citizenship do not mean "becoming normal like others" but creating societies and communities that accept the integration of those who are different, where everyone has a place.

Abuse 7. One Only Contributes to Society Having Fully Completed the Recovery Process

Work (whether paid, voluntary or in the home) is the main way of contributing to the community. Work supports recovery. Most people who use mental health services are able to work, but the rate of unemployment among this specific group is over 70–80 %, which is much higher than in any other disability category.

Self-stigmatisation, expected discrimination and prejudice from services and the community are key factors in the higher unemployment rates, while the benefits offered are a factor promoting exclusion rather than mobilising such individuals to find work. However, one needs to stress that society as a whole benefits from accepting and recognising the equal right to work and equal opportunities for work for persons with mental disabilities.

9.8 Annex 1. Key elements of the recovery model

Key elements of the recovery model		
Element	Description	Sources
Renewed hope and commitment	The feeling of hope and trust in the probability of a renewed sense of self and purpose, which is accompanied by a desire and incentive to do things, is vital for recovery. This sense of hope can come from within oneself or from others who believe in the potential of the individual, even if he does not believe in himself	Davidson et al. (1997, 2001), Deegan (1996a, b), Fisher (1994), Jacobson and Curtis (2000), Jacobson and Greenlay (2001), Mead and Copeland (2000), Smith (2000), and Young and Ensing (1999)
Redefining oneself	The most essential aspect of recovery is perhaps the one relating to redefining oneself and re-evaluating mental illness as a part of a diverse identity that each of us has and not as the dominant social role of the "mental patient"	Davidson and Strauss (1992), Deegan (1996a, b), Fisher and Ahern (2000), Hatfield (1994), Pettie and Triolo (1999), Ridgeway (1999), Spaniol and Koehler (1994), and Young and Ensing (1999)
Reintegrating the illness	The first step towards recovery is frequently described as recognition and acceptance of the limitations the illness imposes and discovering talents, gifts and abilities that allow the individual to pursue and achieve life goals despite the existence of the disability	Deegan (1988, 1993), Hatfield (1994), Munetz and Frese (2001), Ridgeway (1999), Sayce and Perkins (2000), Smith (2000), Sullivan (1994), and Young and Ensing (1999)
Involvement in activities and roles that provide meaning	By expanding into and occupying normal, functional social roles (such as spouse, employee, student, taxpayer, friend) and contributing creatively to the community which the individual himself chooses, the patient lays the foundations for his own recovery	Anthony (1993), Davidson et al. (2001), Jacobson and Greenley (2001), Lunt (2000), Ridgeway (1999), and Young and Ensing (1999)

Key elements of the recovery model		
Element	Description	Sources
Addressing stigma	Individuals must recover from the social consequences and social stigma and from the effects of the illness itself. Recovery includes developing resilience to stigma and/or actively fighting against it	Deegan (1996a, b), Houghton (2004), Perlick (2001), and Ridgeway (1999)
Regaining control	Individuals must take primary responsibility for transforming themselves from people with disability into people in recovery. Regaining control over one's own life contributes to the treatment through a redefined sense of self as an agent and effective subject. Opportunities must be available to people who make choices and people who need to have choices, from which they can choose. People must also be given opportunities to succeed and fail	Anthony (1993), Bassman (1997), Baxter and Diehl (1998), Deegan (1988, 1996b), Fisher (1994, n.d.-a), Frese et al. (2001), Hatfield (1994), Jacobson and Curtis (2000), Jacobson and Greenley (2001), Leete (1994), Lehman (2000), Lovejoy (1982), Lunt (2000), Mead and Copeland (2000), Munetz and Frese (2001), Ridgeway (1999), Smith (2000), Walsh (1996), and Young and Ensing (1999)
Empowerment and exercising rights of citizenship	As the sense of empowerment and control over one's own life emerges, people in recovery begin to demand their rights (such as the right to decide where they will live, who they will love, how they will spend their lives) and assume responsibility for themselves (by paying taxes, voting, volunteering) like any other citizen does	Fisher (1994, n.d.-b), Jacobson and Greenley (2001), Munetz and Frese (2001), Ridgeway (1999), Walsh (1996), and Young and Ensing (1999)
Managing symptoms	Although full remission of the symptoms is not necessary, the ability to manage one's symptoms in some way is a vital condition for recovery. Recovery includes good and difficult times, setbacks and successes and moments when the symptoms may be more or less under control. The change lies in the individual's active involvement in the treatment and his choice to manage his own symptoms, so that they are under his control instead of him passively accepting the services he receives	Deegan (1996b), Fisher (1994), and Ridgeway (1999)
Support from others	Recovery does not happen in isolation. Showing independence in the community where someone has chosen to live and the support he may received from others and from the models one chooses for oneself, be they family members, friends, professionals, members of the community or peers, encourages the individual to overcome difficult moments and reinforces good ones	Baxter Diehl (1998), Fisher (1994), Jacobson and Greenley (2001), Mead and Copeland (2000), Ridgeway (1999), Smith (2000), Sullivan (1994), and Young and Ensing (1999)

This table has been adapted from Davidson et al. (2005)

References

Amering M, Schmolke M (2009) Recovery in mental health: reshaping scientific and clinical responsibilities, West Sussex: Wiley-Blackwell

Anthony WA (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosoc Rehabil J 16(4):11–23

Anthony WA (2000) A recovery-oriented service system: setting some system standards. Psychiatr Rehabil J 24(2):159–168

Anthony W, Rogers ES, Farkas M (2003) Research on evidence-based practices: future directions in an era of recovery. Community Ment Health J 39(2):101–114

Babiniotis G (2002) Dictionary of the modern Greek language with comments on how to use words correctly: interpretative, etymological, orthographic dictionary featuring synonyms, opposites, proper nouns, scientific terms and abbreviations. Athens: Lexicology Centre [in Greek]

Basaglia F (2005) L'utopia della realtà, vol 296. Torino: Giulio Einaudi

Bassman R (1997) The mental health system: experience from both sides of the locked doors. Prof Psychol Res Pract 28(3):238–242

Baxter EA, Diehl S (1998) Emotional stages: consumers and family members recovering from the trauma of mental illness. Psychiatr Rehabil J 21(4):349–355

Benedetti G (1992) New paths in psychotherapy. Psychol Top 5(2):95–140

Bowie CR et al (2010) Prediction of real-world functional disability in chronic mental disorders: a comparison of schizophrenia and bipolar disorder. Am J Psychiatr 167(9):1116–1124

Burns T, Rugkåsa J, Molodynski A, Dawson J, Yeeles K, Vazquez-Montes M, Voysey M, Sinclair J, Priebe S (2013) Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. Lancet 381(9878):1627–1633

Davidson L (2003) Living outside mental illness: qualitative studies of recovery in schizophrenia. NYU Press, New York

Davidson L, Strauss JS (1992) Sense of self in recovery from severe mental illness. Br J Med Psychol 65(2):131–145

Davidson L, Strauss JS (1995) Beyond the biopsychosocial model: integrating disorder, health, and recovery. Psychiatry Interpersonal Biol Processes 58(1):44–55

Davidson L, Chinman M, Kools B, Lambert S, Stayner DA, Tebes JK (1997) Mental illness as a psychiatric disability: shifting the paradigm toward mutual support. Community Psychol 30:19–21

Davidson L, O'Connell MJ, Tondora J, Lawless M, Evans AC (2005) Recovery in serious mental illness: a new wine or just a new bottle? Prof Psychol Res Pract 36(5):480

Davidson L, Stayner DA, Nickou C, Styron TH, Rowe M, Chinman ML (2001) Simply to be let in: inclusion as a basis for recovery. Psychiatric rehabilitation journal, 24(4):375

Deegan PE (1988) Recovery: the lived experience of rehabilitation. Psychosoc Rehabil J 11:11–19

Deegan PE (1993) Recovering our sense of value after being labelled. J Psychosoc Nurs 31(4):7–11

Deegan PE (1996a) Recovery and the conspiracy of hope. Pat Deegan, PhD & Associates, LLC

Deegan PE (1996b) Recovery as a journey of the heart. Psychiatr Rehabil J 19:91–97

Drakonakis N, Spourdalaki E, Tsaousaki K, Peppou L, Stylianidis S (2012) The legislative framework for involuntary psychiatric hospitalisation in Greece: the gap between the law and how it is implemented and the system's "grey areas". Synapsis J 8(27):32–37 (in Greek)

Fisher D (1994) Health care reform based on an empowerment model of recovery by people with psychiatric disabilities. Hosp Community Psychiatry 45(9):913–915

Fisher DB, Ahern L (2000) Personal assistance in community existence (PACE): An alternative to PACT. Ethical Human Sciences and Services, 2(2):87–92

Frese FJ, Stanley J, Kress K, Vogel-Scibilia S (2001) Integrating evidence-based practices and the recovery model. Psychiatr Serv 52(11):1462–1468

Gerard V (2011) L' experience morale hors de soi. PUF, Paris

Giddens A (2004) La Transformation de l'intimité. Sexualité, amour et érotisme dans les sociétés modernes

Greacen T, Jouet E (Dir.) (2012) Pour des usagers de la psychiatrie Acteurs de leur proper vie. Rétablissement, inclusion sociale, empowerment. Érès, Toulouse

Harding CM, Brooks G, Ashikaga T, Strauss J, Breier A (1987) The vermont longitudinal study of persons with severe mental illness, 1: methodology, study sample and overall status 32 years later. Am J Psychiatr 144(6):718–726

Harrison G, Hopper K, Craig T, Laska E et al (2001) Recovery from schizophrenia, a 15 and 25 year international follow up study. Br J Psychiatry 178:506–517
Hatfield AB (1994) Recovery from mental illness. J Calif Alliance Mentally Ill 5(3):6–7
Hochman J (1986) Realité partagée et traitement des psychotiques, Revue française de Psychanalyse, 1643–1665
Houghton F (2004) Flying solo: single/unmarried mothers and stigma in Ireland. Ir J Psychol Med 21(1):36–37
Jacobson N, Curtis L (2000) Recovery as policy in mental health services: strategies emerging from the states. Psychiatr Rehabil J 23(4):333–341
Jacobson N, Greenley D (2001) What is recovery? A conceptual model and explication. Psychiatr Serv 52(4):482–485
Kentikelenis A et al (2011) Health effects of financial crisis: omens of a Greek tragedy. Lancet 378(9801):1457–1458
Kisely S, Campbell LA, Preston N (2005) Compulsory community and involuntary outpatient treatment for people with severe mental disorders. Cochrane Database Syst Rev 20;(3):CD004408
Laird C (2002) Webster's new world dictionary and thesaurus. New World Dictionaries, New York
Lawton-Smith S, Dawson J, Burns T (2008) Community treatment orders are not a good thing. Br J Psychiatry 193:96–100
Leete E (1994) Stressor, symptom, or sequelae? Remission, recovery, or cure. J Calif Alliance Mentally Ill 5(3):16–17
Lehman AF (2000) Putting recovery into practice: a commentary on "What Recovery means to us." Community Mental Health Journal, 6(3):329–331
Liberman RP, Kopelowicz A (2002) Recovery from schizophrenia: a challenge for the 21st century. Int Rev Psychiatry 14:245–255, http://www.tandf.co.uk/journals/titles/09540261.html
Liberman RP, Kopelowicz A, Ventura J, Gutkind D (2002) Operational criteria and factors related to recovery from schizophrenia. Int Rev Psychiatry 14(4):256–272
Lieberman J, Drake R, Sederer L, Belger A, Keefe R, Perkins D, Stroup S (2008) Science and recovery in schizophrenia. Psychiatr Serv 59(5):487–496
Lovejoy M (1982) Expectations and the recovery process. Schizophr Bull 8(4):605
Lunt A (2000) Recovery: moving from concept toward a theory. Psychiatr Rehabil J 23(4):401
Mead S, Copeland ME (2000) What recovery means to us: consumers' perspectives. Community Ment Health J 36(3):315–328
Mental Health Commission (MHC) (2005) Quality in mental health – your views. Mental Health Commission, Dublin
Mentzos S (2008) New trends in psychoanalytical psychotherapy for schizophrenia. In: Tzavaras N, Vartzopoulos I, Stylianidis S (eds) Psychoanalytical psychotherapy for schizophrenia. Kastaniotis Press, Athens, pp 51–84 (in Greek)
Ministerial Decision No. Υ5β/Γ.Π./οικ 46769. 10-year programme to develop mental health units and action (PSYCHARGOS III) (2011–2020). Ministry of Health & Social Solidarity
Ministry of Health & Social Solidarity (2010) Report evaluating the interventions to implement psychiatric reform for the period 2000–2009. Ministry of Health and Social Security, Athens
Ministry of Health & Social Solidarity (2012) Working Group report on revision of the PSYCHARGOS Programme. Ministry of Health and Social Security, Athens
Ministry of Health & Social Solidarity (2013) Report evaluating the interventions to implement psychiatric reform for 2012. Ministry of Health and Social Security, Athens
Molodynski A, Rugkåsa J, Burns T (2010) Coercion and compulsion in community mental health care. Br Med Bull 95(1):105–119
Monahan J (2011) Mandated psychiatric treatment in the community – forms, prevalence, outcomes and controversies. In: Kallert TW, Mezzich JE, Monahan J (eds) Coercive treatment in psychiatry: clinical, legal and ethical aspects. Wiley, Chichester
Munetz MR, Frese FJ III (2001) Getting ready for recovery: reconciling mandatory treatment with the recovery vision. Psychiatr Rehabil J 25(1):35
Ohio Department of Mental Health (2003) Ohio mental health recovery and consumer outcomes initiative, http://www.mh.state.oh.us/initiatives/outcomes/outcomes.html

Pachoud B (2012) Se rétablir de troubles psychiatriques: un changement de regard sur le devenir des personnes. Inf Psychiatr 88(4):257–266
Perlick DA (2001) Special section on stigma as a barrier to recovery: introduction. Psychiatr Serv 52(12):1613–1614
Pettie D, Triolo AM (1999) Illness as evolution: the search for identity and meaning in the recovery process. Psychiatr Rehabil J 22(3):255–262
Presidents New Freedom Commission on Mental Health (2003) Achieving the promise: transforming mental health care in America, http://www.mentalhealthcommission.gov/reports/Finalreport/Fullreport.htm
Racamier PC (1970) Le psychanalyste sans divan. La psychanalyse et les institutions de soins psychiatriques. Payot, Paris
Racamier PC (1980) Les schizophrènes. Payot, Paris
Ridgeway PA (1999) Re-storying psychiatric disability: learning from first person narrative accounts of recovery. University of Kansas School of Social Welfare, Lawrence
Roberts G, Wolfson P (2004) The rediscovery of recovery: open to all. Adv Psychiatr Treat 10:37–49
Rosenfeld HA (1965) Psychotic states: a psycho-analytical approach. Intern. Univ. Press, New York
Sartre JP (1985) Existentialism and human emotions. New York: Citadel
Sayce L, Perkins R (2000) Recovery: beyond mere survival. Psychiatr Bull 24(2):74–74
Searles HF (1965) Collected papers on schizophrenia and related subjects. Karnac, London (reprinted 1986)
Slade M, Amering M, Farkas M, Hamilton B, O'Hagan M, Panther G, Perkins R, Shepherd G, Tse S, Whitley R (2014) Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. World Psychiatry 13(1):12–20
Smith MK (2000) Recovery from a severe psychiatric disability: findings of a qualitative study. Psychiatr Rehabil J 24(2):149–158
Spaniol L, Koehler M (eds) (1994) The experience of recovery. Centre for Psychiatric Rehabilitation, Boston
Stylianidis S, Chondros P (2011) Crise économique, crise de la réforme psychiatrique en Grèce: indice de déficit démocratique en Europe? Inf Psychiatr 87(8):625–627
Stylianidis S, Zoumpourli L, Mazaraki N (2013) Community treatment orders. ATH 6:17–22 (in Greek)
Sullivan WP (1994) A long and winding road. Process Recover Sev Ment Illn Innov Res Clin Serv Community and Rehabil 3:19–27
Vartzopoulis I, Stylianidis S (2008) Psychoanalytical psychotherapy for schizophrenia. Kastaniotis Press, Athens (in Greek)
Walsh D (1996) A journey toward recovery: from the inside out. Psychiatr Rehabil J 20(2):85–89
Warner R (2004) Recovery from schizophrenia: psychiatry and political economy. New York: Brunner-Routledge
Weaver P (1998) Recovery: Plain and simple. In Keynote Address, State Case Management Conference, Tulsa, Oklahoma, Oklahoma Department of Mental Health
White W (2000) Toward a new recovery movement: historical reflections on recovery, treatment and advocacy. Recovery Community Support Program (RCSP) Conference, April 3-5. Retrieved from www.facesandvoicesofrecovery.org
Whitwell D (2001) Recovery as a medical myth. Psychiatr Bull 25(2):75–75
Young SL, Ensing DS (1999) Exploring recovery from the perspective of people with psychiatric disabilities. Psychiatr Rehabil J 22(3):219–231