JOURNAL OF PSYCHOPATHOLOGY 2020;26:147-154
doi: 10.36148/2284-0249-353

Review

An overview of mental health recovery-oriented practices: potentiality, challenges, prejudices, and misunderstandings

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SUMMARY

Objectives

The implementation of recovery-oriented practices in the daily activities of mental health organizations is nowadays a challenge internationally. However, there is a lack of studies on the methodology of these practices and on the challenges faced by organizations in implementing them. The purpose of this paper is to report the state-of-the-art of recovery-oriented practices in mental health organizations.

Methods

This paper is a narrative literature review of relevant articles and prior works that have been central to the topic including the history of recovery-oriented practices, recovery-oriented interventions, advantages, and obstacles in implementing recovery-oriented practices in mental health organizations.

Results

Procedures for implementing recovery-oriented practices in mental health organizations and several recovery-oriented interventions have been tested. Despite unsolved challenges, recovery-oriented practices have shown the potential to improve mental health care, with a positive impact on the quality of life, the autonomy of service users and health outcomes.

Conclusions

The implementation of recovery-oriented practices requires a change in the paradigm of care in mental health services that may need to modify traditional priorities, and also for the stakeholders who need to review, redefine and re-evaluate their roles and personal identities. Thus, specific strategies might be adopted to reduce the fear of innovations and increase the awareness of advantages.

Key words: mental health services, mental health recovery, recovery-oriented practices, recovery outcome, review

Received: October 30, 2019
Accepted: February 3, 2020

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Conflict of interest
The Authors declare no conflict of interest

How to cite this article: Martinelli A, Ruggeri M. An overview of mental health recovery-oriented practices: potentiality, challenges, prejudices, and misunderstandings. Journal of Psychopathology 2020;26:147-54. https://doi.org/10.36148/2284-0249-353

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Introduction

The understanding of recovery as a personal and subjective experience [1], and the theoretical foundations supporting the need to provide recovery-oriented practices are clear and widely shared in many countries [2,3]. The implementation of recovery-oriented practices in daily activities of mental health organizations is nowadays a significant challenge internationally [1]. Efforts in the development of effective strategies are under study [2,3]. Given that the research in recovery-oriented practices is still a field in the

beginning stages, we have limited knowledge of how recovery-oriented practice is effectively implemented in mental health organizations [2,4,5].
The aim of this paper is to provide an overview of current recovery-oriented practices from the beginning to the current state-of-art including recovery implementation issues in mental health organizations, identification of strengths and of obstacles that impede the provision of recovery-oriented practices, and finally caveats to overcome them.

Methods

This narrative review was based on an electronic search that included two databases, PubMed and Google Scholar, and used four search terms: 'mental health recovery', 'recovery-oriented practices', 'recovery implementation in mental health', 'personal recovery', and 'recovery outcome'.
Full text published articles, books, and recovery-oriented practices guidance and procedures for mental health organizations both in English and in Italian from 1980 to 2019 were included. Additional references were identified by a manual search among the cited references.
The chosen eligibility criteria aimed to report and analyze the current knowledge on recovery-oriented practices. Inclusion criteria focused on i) recovery-oriented practices, ii) personal recovery model, iii) recovery-oriented practices guidance and procedures, vi) evidence on recovery-oriented practices.
Exclusion criteria allow to remove texts focused on i) other recovery models (p.e. clinical and/or functional recovery) development, principles, guidelines, procedures and interventions, ii) measures of recovery outcomes, iii) psychiatric rehabilitation.
The selection resulted in 37 references: 20 articles, 6 books, and 9 recovery-oriented practices guidance and procedures for mental health organizations.

Results

The development of the recovery concept

The concept of recovery owes a historical debt to the "moral treatment" pioneered in the 18th century by the Tukes and Pinel at the 'York Retreat' asylum [6,7]. The "moral treatment" is characterized by the effort of fighting mental health disorders by arising in the patients of asylums a sense of responsibility aimed to maintain acceptable levels of self-control, of self-help attitude as expression of the wider tendency of the industrialized society of the 18th century to move from imposed external "coercion" of the body to 'internal coercion' of the 'soul'. In other words, the Tukes showed that moral or psychological forms of treatment in a work-oriented, peaceful and pleasant environment could replace physical restraint [8].
Later, the implementation of deinstitutionalization in the 1960s and 1970s, the increasing ascendancy of the community support system concept, and the practice of psychiatric rehabilitation in the 1980s have laid the foundation for a new 1990s vision of service delivery for people who had a mental illness [9]. The need to define recovery as the main aim of mental health community services was elicited by the awareness of the inadequacy of the deinstitutionalization process, characterized by community services still predominantly focused on the management of the user's crisis [10]. The failures in the implementation of the deinstitutionalization's policies confronted the mental health professionals with the fact that a person with a mental health illness wants and needs more than just symptom relief. People with severe mental illnesses might have multiple residential, vocational, educational, and social needs and desires. These new ideas have promoted the gradual emergence of the recovery vision, which has guided the mental health system from there on [9,10].
Thus, the recovery paradigm has set a positive approach to mental wellbeing suggesting that people previously diagnosed with long-term or enduring mental health problems are able to establish independent and healthy lives even in the presence of symptoms [9-13].

The key principles of the recovery-oriented approach

The recovery-oriented approach is based on the following principles:

- to implement specific and interconnected good practices in a mental health organization;
- to develop person-centered practices aimed to help individuals in living a meaningful life [14];
- to promote hope, and facilitate self-determination [1];
- to put efforts to get a proper understanding of the person's strengths, preferences, and aspirations;
- to support personal choices about life [15];
- to provide a *co-production spirit* between users and professionals, an equal partnership to learn new ways of working together to support users in pursuing their goals [2,17] and to achieve both health and social outcomes [2,15,17];
- to provide access to well-organized services that deliver evidence-based treatments [14,18];
- to assess needs [1-3];
- to predispose comprehensive plans of treatment [19,20];
- to benefit of the specialist skills and expertise necessary for the management of multiple and complex problems, in all areas that are likely to have an effect on outcomes such as finances, housing, employment, and social integration [15].

Finally, the recovery-oriented approach should combine the professional help, and the informal resources from

the community (such as friends, families, employers, education bodies) to enable service users to achieve their goals [1,15,21,22].

The key recovery-oriented practices in daily activities of mental health organizations

The implementation of the recovery-oriented approach in the daily activities of mental health organizations is supported by a series of procedures and guidance.

Recovery-oriented organization

First of all, the translation of the recovery concept into clinical practice implies the change of the organizational culture of the mental health services [1,3,16].

Recovery values need to be embodied in the vision and mission of the organization, and in every management process, including recruitment, supervision, appraisal, audit, planning and operational policies, and assessment of outcomes. These necessary changes need to be understood by the commissioners of services and commissioned through co-production between the commissioners and the local service providers. This requires leadership engagement as well as the commitment of managers and practitioners at the front line, and involvement of all the stakeholders [17]. Thus, professionals and other stakeholders need to review, redefine and re-evaluate their roles and personal identities [10,18,19].

Mental health organizations should implement specific staff training [2,16] and give value to the input of service users, and carers, redefining service user involvement to create a more equal partnership [6,23,24]. Furthermore, job opportunities in the workforce for people who have experienced mental ill-health should be provided [15].

However, the changes of perspective and roles of professionals and service users are not sufficient if they are not supported by attempts to change the organizational culture of mental health services; without this support, the risk is to have an inevitably weak and short term effect [2,16].

Finally, recovery-oriented services must have strong strategic relationships with social care agencies, such as housing, employment, and community networks [20].

In 2010 Shepherd and collaborators, during the IMROC program, elaborated the "10 organizational challenges" that, shown in the Table I, provides a schema that can be used by stakeholders to evaluate the current progress of services to support recovery and define the objectives of change with sufficient validity to implement the auditing processes in community services [3,16,17].

TABLE I. *Making organizations more recovery-oriented (from Shepherd, et al., 2010, mod.)* [23].

Ten key organisational challenges
1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, service user-led education and training programs
3. Establishing a 'Recovery Education Centre' to drive the programs forward
4. Ensuring organizational commitment, creating the 'culture'
5. Increasing 'personalization' and choice
6. Changing the way we approach risk assessment and management
7. Redefining service user involvement
8. Transforming the workforce
9. Supporting staff in their recovery journey
10. Increasing opportunities for building a life 'beyond illness'

Recovery-oriented professionals' skills

Mental health professionals should have competences to qualify their daily practices as recovery-oriented as resumed in Table II.

In Table III are listed the Sainsbury Centre's 10 top practical tips for Recovery-oriented practice that mental health professionals should pursue to adopt the recovery approach [3].

Recovery-oriented interventions

In synthesis, the main recovery-oriented practices that have proved to be evidence-based are: i) peer support workers, ii) advanced treatment directive, iii) Refocus, iv) the Strengths Model, v) the IPS model, vi) the Recovery Colleges, vii) Supported housing, viii) Mental health trialogue [1,2,25].

Peer support workers

Individuals with mental illness who identify themselves as such, and who use their lived experience to support others to recover. Experts by experience, they offer to users and family members their experience, a model of successful care path, emotional closeness, and trust not replacing mental health professionals and with a range of more or less formal approaches within mental health organizations [1,2,5,10]. Evidence show peer workers have a positive effect on several outcomes [25] with a reduction of admission and length of hospital admissions, an increase in service users satisfaction self-efficacy, and empowerment hope and insight, and increase social networks. However, challenges exist in introducing peer workers in mental health organizations and more research is needed [26].

Advanced treatment directive

The formulation of a document that specifies a person's future preferences for treatment, should he or she lose the mental ability to make treatment decisions (lose capacity). An increasingly common variant is the "joint cri-

TABLE II. *Necessary competences for mental health professionals in order to favour recovery.*

Necessary competences according to Farkas M, Gagne C, Anthony W et al. (2005)[14]	Necessary competences according to Carozza P (2006) [10]
The capacity to collaborate.	To consider that people with psychiatric disabilities need not be guarded or assisted, but accompanied to regain their role in the community.
Skills related to inspire, teach and coach.	To know the consequences of the psychiatric disorder, its evolution, its impact on the family, the most appropriate psychosocial interventions.
Skills to facilitate the choice according to the Shared-decision-making process	To provide emotional or instrumental support and help the user to identify his/her goals.
Skills and strategies to promote empowerment, hope, and self-acceptance.	

TABLE III. *Ten top tips for recovery-orientated practice (from Shepherd, et al., 2008, mod.) [3].*

A. Understand recovery
Help the person identify and prioritize their personal goals for recovery (not the professional's goals)
Demonstrate a belief in the person's existing strengths in relation to the pursuit of these goals
Be able to identify examples from your own lived experience, or that of other service users, which inspires and validates hope
Accept that the future is uncertain and that setbacks will occur, continue to express support for the possibility of achieving these self-defined goals – maintaining hope and positive expectations
B. Know how to collaborate
Encourage self-management of mental health problems (by providing information, reinforcing existing coping strategies, etc.)
Listen to what the person wants in terms of therapeutic interventions, e.g. psychosocial treatments, alternative therapies, joint crisis planning etc. Show that you have listened to
Behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together
Indicate a willingness to 'go the extra mile' to help the person achieve their goals
C. Have a broad view
Pay particular attention to the importance of goals that take the person out of the traditional sick role and enable them to serve and help others
Identify non-mental health resources – friends, contacts, organizations – relevant to the achievement of these goals

sis planning", which means to produce a plan for use during a future mental health crisis or relapse [2,27]. Evidence shows the reduction of compulsory admissions in psychotic patients in terms of reduction of costs, of use of services, and greater personal control over the disease [1,25].

Refocus

A program of research, funded by the NHS National Institute for Health Research (Programme Grants for Applied Research), from 2009 to 2014 at King's College London. The aim of REFOCUS was to find ways of making community-based adult mental health services in England more recovery-orientated. The staff is trained in three activities and supported with reflection and supervision sessions: identification of the values and preferences of the user's treatment, evaluation of the strengths, the support offered in the commitment to reach the objectives [2]. The intervention was validated [1] and has a theoretical basis [22,28].

The strengths model

Developed in the mid-1980s, it is both a philosophy of clinical practice and a set of tools and methodologies. Its founding assumption is that the identification and strengthening of the strengths of the person and his/her environment, rather than the identification of his/her deficits and attempts to "repair" them, can facilitate the recovery processes. The adoption of a strengths model-based case management in relation to many areas,

including hospitalization, housing placement, employment, training, symptom reduction, leisure time, social support and family work, highlighted its effectiveness in people with psychiatric disabilities [2,17].

The individual placement and support (IPS) model

The IPS is a psychosocial intervention of supported employment, with a considerable body of evidence for effectiveness in helping people with severe mental illness (SMI) to obtain and maintain competitive employment according to their preferences [29]. IPS assumes that nearly all people with severe mental disabilities can engage in some type of work and that work is a good treatment. Thus, while some vocational models attempt to separate rehabilitation from other treatments, IPS integrates them closely. Studies across the world, mostly RCT (there are 18), and a Cochrane review, have consistently shown that IPS produces better work and overall health and social outcomes compared to other types of employment programs for patients with SMI [2].

Recovery colleges

Recovery colleges or Recovery Education Centre offer educational courses about mental health and recovery which are designed to increase students' knowledge and skills and to help them feel more confident in self-management of their own mental health and well-being. For a person, with lived experience of mental ill-health, this may help them to take control and become an expert in their own well-being and recovery and move on with their life despite their mental health challenges. This will hopefully help them to achieve or work towards whatever is meaningful in their lives [30]. They use an educational paradigm to complement traditional treatment approaches [21]. There is a strong and consistent body of evidence from an increasing number of uncontrolled studies on the positive impact of Recovery Colleges in several areas such as supported self-management education and peer support [31].

Supported housing or housing first intervention

The intervention involves rapid re-housing in independent accommodation, considering that safe and secure permanent housing, regarding their preferences, can act as a base from which people with severe mental illness can achieve numerous recovery goals and improve quality of life. This approach has an emerging evidence base showing improved outcomes and reduced costs.

Mental health trialogues

These meetings are community forums where service users, carers, friends, mental health workers, and others with an interest in mental health participate in an open dialogue. Meetings address different topics, e.g. a task force on stigma-busting, or a workgroup on trauma and psychosis. International interest and experiences are growing but there is not a consistent bulk of evidence on this intervention. A positive effect on more successful collaboration has been found in qualitative research [1].

Advantages of recovery-oriented practices

Literature shows that recovery-oriented practices are advantageous both for service users and mental health organizations. The main advantages are: 1) *Positive outcomes for people with a long-term severe mental illness.* Longitudinal researches show that a significant number of people with a severe mental illness, if treated early, effectively and continuously has a substantially positive evolution. About 50% of people with schizophrenia will recover fully or improve substantially after the initial acute illness, being able to live independently, while 10% remain chronically institutionalized [10,12,13]. Furthermore, the recovery-oriented approach and, particularly the shared decision-making process, has shown evidence in improving self-management, and autonomy [6,15]. 2) *Reduction of health costs.* Recovery-oriented practices have been proved to correlate positively with a reduction of the costs for the health systems because recovery-oriented interactions between different stakeholder groups directly improve the cohesion among stakeholders and the quality of care planning [32]. More recovery-oriented is the care planning, more the service user will be able to achieve his/her personal goals with the aim of living 'a satisfying and meaningful life beyond illness' [33], this will imply increasing contacts with natural community supports, and reduction of the contacts with formal mental health organizations resulting in a cost reduction for health systems [1]. Furthermore, evidence shows that coproduction is cost-effective because it allows having access to the resources of the overall public sector and of the community, resources that tend to be underused even if they do not imply additional costs [24]. 3) *Greater value on the personal knowledge of the individual*. The assumption of the presence of two experts in the clinical encounter (the professionals with their technical knowledge and the service users with their expertise by experience) provides greater job satisfaction for professionals as well as the improved engagement of service users in the management of their own problems [13,15]. 4) *Greater emphasis on the personal priorities of the service user* rather than on the best interests of the service user defined by the professionals. This emphasizes the values underpinning the clinician's work and helps them to understand their role. Furthermore, this may lead the users to better outcomes and enable them to live the lives they want to lead [5,6]. 5) *Re-address the historically subordinate interests of people with mental illness in society.* It provides a means of em-

powering service users and reasserting their rights and citizenship with the potential of greater social inclusion and a potential role for clinicians in helping to promote this [15,23,34].

Challenges for implementing recovery-oriented practice in mental health organizations

Mental health organizations are increasingly trying to implement recovery-oriented practices [1], with relevant progress in the development and implementation of effective strategies.

However, the translation of the recovery concept into practice has to face a series of challenges for the whole organization, and the stakeholders, due to the complexity and variability of the process as services have different historical contexts and organizational structures [2,3].

Obstacles to recovery-oriented practice

Although over the last ten years a growing number of publications have focused on the themes and the possible implications of recovery, mental health organizations and mental health professionals have still considerable uncertainty and criticisms about the precise meaning of these concepts and their effective application in the everyday clinical practices [2,3]. This is probably due to anxiety about new approaches, change, and lack of knowledge about the evidence behind the recovery approach [4,10,25], and deficiency of the recovery phenomenon as a subject of study in the training programs of professionals [2,3].

The lack of knowledge on the key recovery concepts has ended in a series of implausible *negative assumptions and prejudices*, such as the following. 1) *Recovery means the introduction of new services.* A recovery approach may not need a wide introduction of new services, as there is a certain overlap between recovery-oriented interventions and some already existing and evidence-based therapeutic and rehabilitative practices [2,3]. Thus, what is required is only an adjustment of approaches to re-emphasize the priorities of service users [15]. 2) *Recovery increases providers' exposure to risk and liability.* It is true that a recovery-oriented service will require a change in emphasis from risk avoidance to constructive and creative risk-taking. Mental health professionals must seek to differentiate between the risks that must be minimized (self-harm, harm to others) and the risks which people have a right to experience, the risk that may enhance personal recovery [15]. The recovery approach should encourage opportunities for growth and change but, of course, this must be done in a responsible way, being risk-aware but focused on safety planning in an increasingly collaborative approach that promotes people taking responsibility themselves for ensuring their safety with service supports [4,6,15]. 3) *Recovery adds to the burden of the professional.* On the contrary, it has been shown that if recovery principles and values are integrated and not simply added on or exchanged with previous practice, the result is that assessments and interventions would be collaboratively agreed by staff and service users with the capacity to erasing unnecessary tasks and achieving greater job satisfaction [10,15]. 4) *Recovery-oriented practices are an anti-medical profession model.* In reality, recovery-oriented interventions incorporate medical approaches into their holistic vision. Thus, rather than in conflict or in competition with one another, these models can be seen as complementary and potentially useful to one another [2,3,13].

Furthermore, a series of common *misunderstandings* towards the meaning of recovery key-concepts has been detected 1) *Recovery services are neither cost-effective nor evidence-based.* On the contrary, evidence supports the introduction of recovery principles, both according to first-person accounts and randomized controlled trials [35,36]. Literature proves the effectiveness of recovery models for the communication about schizophrenia, the approaches to the self-management of symptoms, and for gaining and retaining open employment [2,3,13]. In addition, both health and social benefits have been found. Feeling more "control" of one's life and finding meaning beyond illness are outcomes with positive health consequences. 2) *Recovery is nothing new as it means that the person is cured.* More precisely, recovery has a clearer focus on the person and his/her life, while the term 'cure' is prevalently focused on the concept of illness [15]. 3) *Clinical, functional and personal recovery cannot be integrated.* This is not true as it has been proved that these concepts are complementary and synergistic even if they cover different domains [8].

Conclusions and implications for research and practice

Overall, the results of the review suggest that the shift to a recovery-oriented approach represents a key challenge in the provision of recovery-oriented practices in mental health services [2,3] because it requires a transformation of the paradigm within the practices that are delivered.

This transformation is not easy to assume, given that many rehabilitation models are based on the idea that individuals cannot recover from mental illness [10], while recovery means 'living a life beyond illness' and 'building a meaningful and satisfying life', as defined by the person him/her-self, whether or not there are ongoing or recurring symptoms and problems' [33]. "Building a meaningful and satisfying life" for the service user is not

the result of good intentions, or optimistic ideology neither of the power of positive thinking because recovery does not happen naturally, and is not only a lifestyle of continuous experiences, more hope for the future, and empowerment. The adoption of the recovery approach by a mental health organization means involving all the stakeholders (service users, family members, professionals, and managers) in a common effort to combine the best rehabilitative practices with personal acceptance and positive self-reinforcement of the users to achieve outcomes such as the remission of symptoms, the improvement of social and work functioning, and the increase of social and life skills. The full partnership or synergy of all these figures represent the necessary engine to promote recovery, improving attitudes and initiatives that aim to empowerment, self-responsibility, hope and user satisfaction [13].

However, despite the spread of procedures and guidance for mental health organizations and professionals about the way of implementing the recovery-oriented practices, and the growing bulk of evidence about the effectiveness of the recovery-oriented approach and interventions in improving overall outcomes, negative assumptions, prejudices, and misunderstandings towards the recovery concept already exists and represents a frequent reason of lack of an adequate adoption of the recovery-oriented approach in the daily mental health activities of the organizations.

To contribute to overcome the underlined challenges and effectively aiming at 'building a meaningful and satisfying life' for service users, some suggestions for researchers might be useful: 1) to identify the substantial changes necessary to address the specific procedures that impede the delivery of recovery-oriented practices [5]; 2) to prove the impact of recovery approach on health costs [5,24]; 4) to implement both qualitative and quantitative pilot studies in the field to fill the lack of knowledge [37]; 5) to recast recommendations for EBM and mental health policies, providing standardized procedures for recovery-oriented practices to improve the integration between EBM and recovery approach [34,37].

For professionals working in mental health organizations, we suggest 1) to improve organizational dynamics, promoting in figures to coordinate and supervise the group of mental health professionals to improve their skills and motivate them, and introduce elements of change into the system; 2) to adopt strategies aimed to reduce the fear of innovations and increase the awareness of advantages in all the stakeholders; 4) to promote the dissemination of recovery-oriented practices as good practices [10]; 5) to develop adequate training for the recovery approach [10,25]; 6) to fight demotivation and disinterest involving the professionals in programmatic decisions oriented to coproduction [10]; 7) to contrast the internalization by service users of the concept of disability as a lack of motivation, interest, hope, and life objectives [11] that interfere with the individual's autonomy in work, education, family and social relations, recreational, and independent living [13]; 8) to confront both self and social/public stigmas, that are secondary handicaps for people with mental health disability, who are one of the most socially excluded groups in society [6,13].

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