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Bejerholm, Ulrika; Roe, David

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REVIEW ARTICLE

Personal recovery within positive psychiatry

Ulrika Bejerholm[a,b] and David Roe[c,d]

[a]Department of Health Sciences/Mental Health, Activity and Participation, Lund University, Lund, Sweden; [b]Center for Evidence-based Psychosocial Interventions (CEPI), Lund University, Lund, Sweden; [c]Department of Community Mental Health, University of Haifa, Haifa, Israel; [d]Department of Medicine, Aalborg University, Aalborg, Denmark

ABSTRACT

Background: One goal within positive psychiatry is to support the personal recovery of persons with mental illness and providing opportunities for well-being.

Aim: The current article aims to introduce readers to the concept of personal recovery and the potential and importance of recovery-oriented services and measures.

Methods: A literature review was conducted to help consider the domains of 'personal recovery', 'recovery-oriented services/interventions', and 'measures'. A database search was complemented with a web-based search. Both medical subject heading (MESH) terms and free-text search terms were used.

Results: Literature from research journals, grey literature, and websites were included. Within this context, recovery does not refer to a cure but involves a process in which a person acts as an agent to develop new goals and meaning in life, despite and beyond limitations posed by the illness and its consequences. A positive focus on recovery is in sharp contrast to historical deterministic and pessimistic concepts of mental illnesses. Recovery-oriented services such as peer support, assertive community treatment, supported employment/education/housing, illness self-management, and decreasing self-stigma are highlighted. A review of 27 measures that focus on personal recovery and promotion of well-being are also discussed.

Conclusions: The literature overview presents perspectives and knowledge of how to develop positive psychiatry, how mental health services and their partner organizations may become more recovery oriented and help persons reach well-being and a better quality of life. This study is limited to a narrative review and may precede future systematic reviews.

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Introduction

The conceptualizations of 'positive psychiatry' and 'personal recovery' function well together, as they contribute to the positive mental health movement which emphasizes opportunities for well-being among persons who experience mental illness. Both imply optimism that improvement is possible and well-being is achievable. Positive psychiatry is regarded as the science and practice of understanding and promoting well-being through services/interventions and assessments/measurements [1]. Positive psychiatry encompasses psychological aspects such as optimism, resilience, personal mastery, coping, self-efficacy, social engagement, and spirituality (i.e. meaning in life and wisdom). The personal recovery framework involves similar constructs such as connectedness, hope, optimism, meaningfulness, identity, and empowerment [2]. A holistic and optimistic perspective on recovery is fundamental in both. The concept of personal recovery is of particular importance to consider within the context of positive psychiatry since it involves the process by which a person attempts to develop new goals and meaning in life beyond the catastrophic event of having a mental illness [3,4]. To our knowledge, no literature review or discussion paper has previously introduced the movement and concept of personal recovery in connection with positive psychiatry, and what recovery oriented services and measures may be applicable for the development of positive psychiatry.

Well-being is central in positive psychiatry and emphasizes the experience of meaning and self-actualization, rather than positive emotions and joy actualization, as often mistakenly thought [2]. In the personal recovery process, promoting well-being and support in building hope and optimism are core features. Both positive psychiatry and personal recovery focus on positive attributes and strengths, which is in sharp contrast to the historical deterministic and pessimistic concepts of mental illnesses. For example, since Kreplin's dementia praecox at the end of the 19th century, schizophrenia was thought to follow a progressively deteriorating course. This left a heavy cloud over a person's hope or attempts to rebuild a life after being labeled schizophrenic. People were coerced into accepting that they had 'broken brains' and were pressured to take medication that often had considerable side effects, avoid stress or 'life' itself

CONTACT Ulrika Bejerholm ulrika.bejerholm@med.lu.se Department of Health Sciences/Mental Health, Activity and Participation, Lund University, Lund, Sweden

(which by definition is not stress-free), live for long periods or possibly their entire life in restrictive environments, and hope at best to be 'stabilized'. It was not until the 1970s that longitudinal clinical and epidemiology studies challenged the widely adopted notion that persons with mental illnesses could not get better [5–13]. In parallel, persons with life experience of mental illness started to share their stories of recovery, which brought attention to a new voice and an alternative to the dementia praecox 'story'. In addition, qualitative research began to explore subjectivity and a broad range of experiences rather than focusing narrowly on symptoms. This began to challenge the notion of clinical recovery (which commonly meant 'symptom reduction') as the only desirable outcome [2,14], and enriched and deepened the understanding of personal recovery. Along with this important development grew, the recognition grew that traditional mental health services seldom provided hope or support personal goals, and often promoted dependence, and fostered stigma [15,16]. Within this context, the vision of personal recovery emerged.

The shift from the historical view of mental illnesses to a positive vision and belief that persons can improve and embrace the process of personal recovery has generated new policies and services. Policy is defined as the official statement of a government conveying an organized set of values, principles, objectives, and areas for action to improve mental health of a population [17]. In New Zealand, policy was set as early as 1998 [18], and in the USA, Australia, Ireland, and the UK, policies began in 2001 and onward [19–21]. In Israel, the progressive law of the Rehabilitation of Persons with a Psychiatric Disability in the Community has brought about a rapid development of recovery-oriented services and their implementation [22,23].

In the Nordic countries, policy is in progress [24,25]. In the Swedish national guidelines for persons with schizophrenia, recovery is a vital goal and the importance of welfare services providing integrated support according to individual needs is particularly stressed [26]. In Denmark and Norway, the policy is close to practice [27,28]. In Denmark, for instance, recovery-oriented services (ROS) are currently being implemented in community mental health services with support from the National Board of Social Services. In Finland, the recovery-oriented service of Open Dialogue has led the way [29], and the Finnish Association of Mental Health (FAMI) has taken a leading role in integrating mental health into existing national and international policies [30]. In 2011, the Council of the European Union made it clear that mental health and well-being should be included in policy [31]. The shift in policy from a treatment directive to a person-centered and recovery approach is necessary to more fully support the well-being of persons with mental illnesses [20]. This notion is in accordance with the shift of focus of positive psychiatry, from a traditional psychiatry with the goal of symptom relief to a psychiatry which concentrates on recovery, increased well-being and posttraumatic growth [1]. It can therefore be assumed that the understanding of personal recovery, and its related services and measures, may contribute to the development of a more positive psychiatry for the benefit of the service user and their loved ones.

Aim

The aim of this article is to introduce and discuss the concept of personal recovery and highlight recovery-oriented services and measures. We suggest that this review of personal recovery can inform the development of positive psychiatry in mental health.

Materials and methods

This literature review was conducted to help to provide an overview of the domains of 'personal recovery', 'recovery-oriented services/interventions', and 'measures. It is a narrative literature review and synthesis of both qualitative as well as quantitative literature coordinated in a comprehensive text [32,33]. Database searches of CIHNAL, MEDLINE, and PsychINFO were performed; both medical subject heading terms (MeSH) and free-text search terms were used. The MeSH search terms used for each bracket were related to the population and the three domains: ['mental health' OR 'mental disorder' OR 'mentally ill persons'] AND ['mental health recovery'] AND ['rehabilitation' OR 'vocational rehabilitation' OR 'activities of daily living' OR 'mental health services' OR 'community mental health services' OR 'peer group' OR 'assertive community treatment' OR 'employment, supported' OR 'person-centered therapy'] AND ['patient reported outcome']. The search resulted in 3539 articles. In order to narrow down the search, a free-text search that included the wording of the three domains and the bracketed MeSH strings was performed. The personal recovery domain search resulted in 744 articles, the 'recovery oriented services' in 74 articles, and finally, when 'measure' was added, a hit of 55 articles was found. The search was complemented with a web-based search in Google Scholar on grey literature and homepages of organizations. Finally, a review of literature reference lists was performed. Two quality indicators were included in order to address the quality of the articles retrieved. First, the hits needed to include research on both mental disorder and personal recovery and its meaning, and second, that known articles could be found among the hits. The titles were chosen and then the abstracts that corresponded to the domains. Finally, the articles were read through and organized according to the three domains and coordinated into text that included the citations of the literature reviewed. Our purpose was not to provide a systematic overview of the literature, but rather to enable the literature to enrich the discussion of the chosen domains. Accordingly, the reference list should not be viewed as comprehensive.

Results

Recovery

In order to understand how personal recovery has emerged within a few decades to become a powerful influential concept, it might be helpful to start from the basics of the personal experience of being diagnosed with a mental illness. For this purpose, we have illustrated a vignette, see Table 1.

Table 1. A clinical vignette.

Imagine an 18-year-old boy leaving home for the first time and moving to a different city to attend his first year of university. Imagine him dealing with the profound transition of leaving a supportive, or at least familiar environment, of family, friends, and routines, and entering an entirely new setting of people and demands. It might be exciting and stressful to try to make new friends and cope with challenging educational demands. And in the midst of this all, he begins to have unfamiliar experiences, perceptions and/or beliefs that others do not seem to understand. These cause increasing experiences of conflict, tension, and alienation. A sudden event, or a series of events, like those described may lead to distress, confusion, and hinder the young man's ability to relate or function. This in turn may lead to contact with the mental health system. Experiences may vary, but even under the best of circumstances often include being labeled, medicated, subject to treatments one did not necessarily choose, were imposed, or involved restraint and various degrees of loss of freedom. Then even when things seem to improve on the surface (for example, when symptoms become less severe or resolve), this young man, who until recently lived a normative life, is likely to be subject to stigma. His behavior will be interpreted through the lens of a 'remission', which will make him vulnerable to internalizing his mental health label and adapting the only identity that has not yet been 'stripped' from him—that of a patient. His life opportunities, to make friends, rent an apartment, and obtain work, are likely to be hindered as long as his label of having experienced and been treated for a psychotic episode is known. An alternative to this unfortunate and common sequence of events is working towards promoting personal recovery. This would take the form of respecting, being curious about and listening to a person's experience no matter how different it might be from the perspectives of professionals. This alternative entails focusing on a person's strengths rather than symptoms and narrow treatment goals. This alternative entails focusing on a person's strengths rather than symptoms and narrow treatment goals.

Personal recovery is an ongoing process and a human journey of finding a way to live a meaningful life and develop valued social roles in the community even when symptoms are present [34]. The process is nonlinear and deeply personal. It is a process during which a person tries to take stock of their life and identity. It often involves the person identifying what he or she would like their life to look like, and begin to sketch a map how to get there while seeking the needed support and acquiring the needed skills. The right to one's personal story is as crucial as the right to reject the names and labels which they were expected to passively adapt to. Personal recovery does not refer to clinical recovery and symptom reduction, but rather to constructing a personally meaningful life of choice [35]. For example, choosing a working life can be a vehicle for well-being. A 40-year-old woman who had not worked for ten years was finally supported in concurrence with her goals. After a year in supported employment, she got a job [36] and said: *'I was supported by my employment specialist and case manager who believed in me and got a job. But I was laid off for productivity reasons. The second job I found myself, through my own contacts. I really like working. Before, I was isolated at home with bad finances. Now I get a pay check … I caught up with my case manager the other week and he did not even recognize me, since before I looked like the living dead, and now you can tell I'm doing well' (p. 185-186)'*.

There is no single definition of personal recovery since it is inherently a subjective, self-defined process that challenges assumptions about normality. The most cited definition is that of Anthony [3], where recovery is described as *'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness'* (p. 17). Another definition, perhaps closer to positive psychiatry, is described as '*a process of positive adaptation to illness and disability, linked strongly to self-awareness and a sense of empowerment*' [37]. The construct is complex, as concluded in both an older [38] and more recent reviews on personal recovery [39,40]. Different meanings reflect 'different needs at different points' in the recovery process of persons with mental illnesses [20]. Four main areas are suggested for research: the definition of recovery, reliable measures, barriers to recovery, and how effective recovery-oriented approaches may be in promoting recovery [38]. Nonetheless, the rapidly growing literature of first person accounts has provided a foundation from which a conceptual framework of CHIME has been identified. The acronym stands for *connectedness* (i.e. support from others and being part of the community), *hope and optimism for the future* (i.e. motivation to change, positive thinking), *identity* (i.e. overcoming stigma, rebuilding or redefining sense of identity), *meaning in life* (i.e. meaning of mental illness experiences, quality of life, social roles and goals), and *empowerment* (i.e. personal responsibility, control, focusing on strengths). CHIME has been developed based on the synthesis of 115 original papers that reflect user experiences of personal recovery in English-speaking countries [2,20]. Empowerment plays a central role in the understanding of personal recovery [34], is a core concept of the World Health Organization (WHO) vision of mental health promotion, and is stressed as the key priority for stakeholders and mental health services for the next decades [41]. Historically, the power and voice of persons with mental illnesses has been lacking. Empowerment takes the form of feeling entitled to the basic human right to make personal choices and take responsibility and live up to the consequences, just like anyone else. It is about becoming stronger and more confident, particularly in controlling one's life and claiming one's rights. Empowerment helps to adopt autonomy and self-determination and exerts influence over decision-making processes that impact self-esteem and self-efficacy [2]. Since mental illness, its treatment, and its personal and social consequences commonly generate a feeling of helplessness, mental health services must mobilize social support and networks to empower individuals through difficult transitions and periods of vulnerability [41]. Support, genuine encouragement, and conveyance of expectations of the capability to master different life situations are shown to be central for recovery [42] and positive psychiatry [1,4].

Recovery-oriented services and their positive impact

Recovery-oriented services (ROS) describe mental health treatment and interventions that are informed by an understanding of personal recovery as described above. There has been far more research on illness than on well-being [43]. ROS attempt to be person-centered, respect decision-making, and recognize the critical role that self-determination plays in

improving well-being [43–49]. Within this context, the role of professionals requires creating a trustful, empowering, and hope-inspiring relationship that is based on choices of 'what matters' [34]. In the next section, we will describe some of the ROS mentioned in the reviewed literature, of which most are evidence-based practices for persons with severe mental illnesses [49]. However, the services may be relevant for promoting well-being for a wider range of populations, which is in line with positive psychiatry, i.e. the science and practice of understanding and promoting well-being through services/interventions and assessments/measurements [1].

Peer support

Peer support forms an essential part of ROS in personal recovery [49], and has the potential of doing the same for positive psychiatry. Although program interventions take different forms [50], they share the assumption that people who have dealt with mental illness, or have *lived experience of mental illness* [51], are in a unique position to provide support and hope to others coping with similar challenges. Peers help individuals become active participants in their own recovery process, breaking out of the passive and isolating 'mental patient' role, and identify strengths and goals. Peers model community integration as well as personal autonomy and self-worth. In clinical settings, peers work collaboratively with other team members and are part of the professional staff [50]. Recent reviews have concluded that randomized trials on the effectiveness of peer support is lacking [52,53]. Other literature stresses that peer support services are feasible and beneficial in reducing re-hospitalization rates, increasing social integration, and improving quality of life [50]. If a peer supporter is included in the case management team, the patient does as well as or better than someone who does not get this service [54]. This team constellation may reduce the risk of re-hospitalization for persons with recurrent readmissions, leads to better clinical outcomes, and reduces the need of mental health services in the long term [55,56]. To conclude, experience-based and quantitatively based research show that peer support services provide and maintain a sense of hope and control, and increase experience of social inclusion and life satisfaction [54,56], in line with the ideals in positive psychiatry. However, more rigorous research is this area is needed [52,57].

Assertive community treatment

Providing intense community-based treatment services in the natural living setting have proven to stabilize housing in the community, reduction of hospitalization and long-term inpatient treatment, and homelessness. The Assertive Community Treatment (ACT) model was developed for this purpose [58] and includes a greater intensity of staffing than common (1:10 ratio of clinicians: clients, compared to 1:30 or higher in standard case management), the delivery of most services are in the community (rather than the clinic), the sharing of caseloads across clinicians to reduce burnout (rather than individual caseloads), and full-time coverage by the interdisciplinary ACT team. Full-time coverage is mandatory so that treatment is less scattered and fragmented (including specialists in employment and substance abuse). The team provides support in medication, housing, substance abuse, everyday life problems, supported employment, and emergencies (rather than day-time coverage with separate emergency services) [59,60]. ACT is effective at stabilizing housing in the community, including reducing hospitalizations and homelessness, modest reductions in symptoms, drop-out from treatment, and improving chances for employment [61–64]. New standards of ACT are updated to ensure that evidence-based practices for the treatment of schizophrenia are provided [65]. Fidelity to the model explains variations of effectiveness between trials [66]. International research shows mixed results since ACT challenges gaps in welfare service [67–69], and requires adaptation for different systems [70,71]. To meet these challenges, the Flexible ACT model (FACT) has been introduced in the Netherlands, and is an emerging research field [72]. Nevertheless, providing community-based mental health services has been widely adopted in service systems [73]. To integrate mental health support in the community environment instead of a hospital or outpatient environment can be critical for personal mastery and self-efficacy related to the challenges consumers have in their daily lives. Thus, the environment plays a critical role for ensuring positive mental health [1].

Supported employment, supported education, and supported housing

Supported Employment is a value-based service built on the philosophy that anyone can gain competitive employment if provided with the right job and appropriate support. Individual Placement and Support (IPS) is the evidence-based model of supported employment for persons with serious mental illness and is defined by a fidelity scale [74]. Eligibility is based on the user's personal recovery goals of work and is according to a zero-exclusion criterion. Thus, remission of symptoms and avoidance of substance use are not required. Support is provided according to informed choices, support needs, and preferences, and the role of the employment specialist and members in the support network. This means that mental health professionals, employment and insurance services officers, employers, friends and family members [75] are to build egalitarian relationships with the service users. IPS focuses on a rapid search for competitive employment in an integrated community setting ('place-train'). There is an extensive body of research that supports the effectiveness of IPS for improving competitive employment for persons with serious mental illness [76–78]. A recent overview that involved 3022 total participants included 17 randomized clinical trials and two follow-up studies from around the world. On average, 55.1% of IPS participants reached employment compared with 19.5% in traditional vocational rehabilitation (RR 2.40; CI 1.99-2.90) [52]. The evidence of non-vocational outcomes is less clear [77,79,80]. A Dutch 5-year follow-up study showed that IPS participants spent less time

hospitalized [81]. A Swedish trial revealed that IPS was more effective in terms of empowerment and quality of life [82]. The lived experience of IPS, as reflected in qualitative research, reveals that employment specialist professionals bring hope and resources and put them at the center of attention in the recovery process [83]. Participants experience the relationship as personal and helpful [84,85]. An emerging evidence base of trials from Sweden [86], Denmark [87], and Norway [88] is being developed for supported employment for persons with affective disorders. The trials that systematically integrated cognitive behavioral therapy strategies in the IPS service had an effect on employment outcomes [86,88]. Effects on depression and empowerment scores were also shown [86,89]. In this sense, participating in supported employment and finding a job is central for recovery [34]. Within positive psychiatry, work may very well be viewed as a 'well-being therapy' [1,4].

Supported Education is an important service since the early onset of mental illness often results in premature termination of educational attainment [90]. To address this problem, increased attention has been paid to improving educational standing [91–93]. Supported education services are delivered according to various models, including on-site support, mobile teams, educational specialists based at mental health agencies, and on-site campus-based services [94,95]. Most research has focused on programs that are integrated with IPS-supported employment, and show greater improvements in work and studies [96,97]. However, the impact of first episode programs on education remains modest [98]. Less research has focused specifically on education as a primary outcome and across a broader age range [99]. Randomized trials are needed to untangle the evidence for supported education and its effect on educational achievements from supported employment.

Supported housing is a general approach to help persons with mental illnesses establish and maintain stable residences with the ongoing support of mental health professionals [100]. Similar to supported employment and supported education, supported housing emphasizes the importance of helping individuals obtain housing first, and then providing ongoing support as needed, not the other way around. The *Housing First* approach is based on the premise that persons with mental illness have a basic right to stable housing [101,102], regardless of the nature of any problematic behaviors, and then attending to treatment and other needs that may threaten maintenance of independent living [101].

Illness self-management

There are different programs which have been developed to teach and practice illness self-management skills. The most comprehensive program is the Illness Management and Recovery (IMR) program, which is based on a systematic review of 40 controlled studies [103], and identifies four strategies associated with improved illness self-management across several studies: (1) psychoeducation about mental illness and its treatment, (2) behavioral tailoring to facilitate adherence by incorporating taking medication into one's daily routine, (3) developing a relapse prevention plan, and (4) teaching coping strategies for persistent symptoms. The IMR program was developed to integrate the four empirically supported illness self-management strategies into a comprehensive intervention. As part of the recovery process and to motivate clients to enhance self-management skills, clients firstly set personal goals that stem from their vision of their personal recovery. Then, they learn how to manage their illness more effectively so that the illness becomes a less dominant part of their life, allowing them to focus primarily on pursuit of their recovery goals. Much research has supported the efficacy of training clients in illness self-management [104,105]. Several multi-component programs that provide psychoeducation and target symptoms and relapse prevention have been shown to be effective, which forms a central part of the mental health promotion features in positive psychiatry [4]. These include personal therapy [106,107], skills training for community reentry following hospitalization [108], and Wellness Recovery Action Planning [109]. In addition, several RCTs have supported the effectiveness of the IMR program at improving illness self-management and associated outcomes [103]. The first three studies were each conducted in a different country, including the U.S. [110], Israel [111], and Sweden [112].

Decreasing self-stigma

Removing barriers such as the impact of stigma is crucial in promotion of personal recovery [39]. Deegan [51] posed the powerful question, '*How do we develop a sense of ourselves and again reclaim and recover our sense of value when we have been devalued and dehumanized?*'. Narrative Enhancement Cognitive Therapy (NECT) was developed in an attempt to help meet this challenge and reduce self-stigma [51]. NECT is a structured, manual-based group intervention of 20 sessions. In NECT, participants are firstly encouraged to reflect and share the way they describe their experience of self and their illness (or any other way they define or understand what brings them to seek help). This sets a constructivist tone to encourage active exploration. Second, in a psycho-educative interactive manner, concepts of stigma and self-stigma are introduced and discussed in relation to myths, generalized negative attitudes, research, and personal experience. Special emphasis is put on self-stigma is a construction that derives from public stigma and would never have existed had there not been stigma. Third, participants learn and practice cognitive restructuring techniques to identify and combat self-stigmatizing beliefs, in order to enable new ways to cope. The fourth step involves constructing and sharing narratives, to facilitate the process of meaning-making and forming richer and more complex narratives that challenge narrow self-stigmatizing ones. Finally, NECT ends as it begins, with describing the process and experiences related to illness and self over time. Now, however, new perspectives have hopefully been developed. Qualitative [113] and quantitative research show that NECT is effective in reducing self-stigma, and improving self-esteem, quality of life, and hope [114–117].

Measurement challenges and measures used

In positive psychiatry, the ability to measure positive outcomes, like well-being, is central [4]. Likewise, measures are needed to reflect the personal recovery process and the outcome of ROS [118]. However, being in recovery is an individual process that cannot be fully understood or reduced to constructs easily measured. Even though it may be difficult to grasp recovery experiences, an important step is to operationalize and use positive psychosocial outcomes and standardized measures that have strong psychometric properties [2,4]. The lack of adequate and valid instruments is a problem [80]. Since there is no consensus on the recovery concept, measures vary in their conceptual foundations and recovery domains [119,120]. In 2011, Burgess and colleagues [120] summarized measures with sound psychometric properties that were brief ($\leq$50 items), a review we recommend for further reading. However, since our aim of this article is to provide with an overview, we want to introduce these measures that are used for consumers: Recovery Assessment Scale (RAS) [121]; Illness Management and Recovery (IMR) Scales [122,123]; the Stages of Recovery Instrument (STORI) [124], and STORI-30 [125]; and the Recovery Process Inventory (RPI) [126]. The Mental Health Recovery Star (MHRS) assesses the progress of being in recovery across 10 dimensions from a first person perspective [127]. For additional reading, a review on personal recovery from 2013 [128], identified yet another seven measures that all corresponded to the domains of the CHIME framework: Mental Health Recovery Measure (MHRM) [129,130], Psychosis Recovery Inventory (PRI) [131], Questionnaire about the Process of Recovery (QPR) [132], Recovery Markers Questionnaire (RMQ) [133], Recovery Star (RS) [134], Self-Identified Stage of Recovery (SIRS) [135], and Short Interview to Assess Stages of Recovery (SIST-R) [135]. The CHIME domains are also proposed as relevant to address in relation to the perception of staff support [136], which resulted in the 20-item INSPIRE and 5-item Brief INSPIRE (one item per CHIME domain) measures [137]. A Swedish validated version is available [138]. With regard to the central CHIME domain of empowerment, we address the consumer-constructed Empowerment Scale by Rogers and colleagues [139]. It has helped to explore associations between empowerment and stigma, depression and psychotic symptoms, but also positive outcomes of interest for positive psychiatry such as self-esteem and self-efficacy, level of engagement in activities and community life, and quality of life and well-being [140,141]. At the service level, several measures may help to evaluate the process of implementing a more recovery based service, such as the Recovery Oriented Systems Indicators Measure (ROSI) [142], the Recovery Self Assessment (RSA) [143], the Recovery Oriented Practices Index (ROPI) [144], and the Recovery Promotion Fidelity Scale (RPFS) [145] were deemed relevant [120].

Community inclusion and having meaningful social roles and activities are also important when in recovery [146,147], which are focuses in line with the recovery goal and the health promoting features of positive psychiatry [1]. The lived experience, as it unfolds over the day, can be visualized and understood from a time use perspective. The Profile of Occupational Engagement in persons with Severe mental illness (POES) was developed on the basis of time use research of persons with mental illness [148,149]. POES is useful in mental health practice and supports the dialog about, and measurement of, time use and activities and related experiences as it reflects the natural flow of daily life. POES builds on a self-report diary and has an ecological perspective on activities, social and geographical contexts, and personal experiences. On the basis of the diary, nine items help to assess the extent of meaningful social roles and activities, and whether persons are engaged in meaningful daily activities, social roles, and being connected to the community. The Experience Sampling Method (ESM), or Ecological Momentary Assessment (EMA), is another time use measure which helps to collects data at certain times that are close in time to life experiences. The ecological validity of time use measures is high [150], and mobile phones can be used to collect data. The expansion of positive lifestyle interventions in positive psychiatry is emphasized by Jeste et al. [1]. This notion supports the applicability of time use measures. They could help assess the balance of well-being and distress, and support the orchestration of meaningful activities in daily life.

The shift from a traditional medical model to a focus on personal recovery, inherent in the conceptualization of both positive psychiatry and personal recovery [1,4,47], presents the challenge of creating opportunities for people to improve their well-being and quality of life [2,151]. Quality of life, i.e. satisfaction with various life domains or life situation, is an important aspect of personal recovery [146,147]. Quality of life is essential to address since quality of life ratings often stay low even though treatment has ended and symptoms have decreased [152,153]. The number of quality of life and well-being measures is large, but include the Manchester Short Assessment of Quality of Life Scale (MANSA) [154], which covers twelve items on life satisfaction as a whole and on various life domains, i.e. security and safety, housing, finances, vocational status, friends and family, sex life, and mental and physical health. Each item is rated on a seven-point scale, and a higher score refers to a higher level of satisfaction. The WHO-5 Well-being Index [155,157] addresses subjective positive mental health by means of the components of being cheerful, interested, calm and relaxed, active and vigorous, and waking up feeling fresh and rested. The six-point Likert scale helps to address when the feelings have been present, ranging from none of the time to all of the time in the past two weeks. The WHO-5 is also the most used measure for addressing mental health [158]. Interestingly, the recently developed Recovering Quality of Life (ReQoL) connects recovery to quality of life outcomes. Its themes consider activity, hope, belonging and relationships, self-perception, well-being, autonomy, and physical health. It is a self-report instrument, with the choice of 10 or 20 items. ReQoL is assumed to complement the EQ-5D (European Quality of Life-5 Dimensions) with regard to the mental health group as a whole, and can be used to calculate quality-adjusted life-years (QALYs) [158].

Both recovery measures and standardized objective measures are needed in order to monitor the recovery processes, to help maintain engagement, celebrate progress, and to better understand reasons and overcome barriers [159]. Such efforts are often part of Routine Outcome Measurement (ROM) of Patient Reported Outcomes, which has been developed in different countries [160]. ROM is a powerful tool to promote recovery and is intended to be used by various stakeholders, including consumers, practitioners, agency directors, and policy makers [161]. ROM has generated important research findings, including that QOL and the impact of symptoms on functioning are significant predictors of future hospitalization [162].

Discussion and reflections

A person's hope and expectations for quality of life and well-being are imperative. Yet they have generally been overlooked and downplayed. It is critical for mental health services to help support hope, positive attitudes, provide opportunities that enhance the recovery process, and evaluate services primarily based on the degree to which they achieve these. From the perspective of positive psychiatry, it is essential that services take inspiration from the understanding of personal recovery perspectives, interventions and outcomes outlined above.

In order to support positive psychiatry, professionals need to focus on the whole person and the personal meaning of recovery for an individual. This is important since it is not possible predict achievements and personal recovery on the basis of clinical assessment of psychopathology alone [21]. Instead, the role of recovery oriented professionals in positive psychiatry is strongly that of providing hope and power, and starting a dialog with the consumers and others in their natural supportive network. To create a partnership relationship, where the so called 'little things' like positive micro-affirmations in acts and gestures also matter in the reciprocity with the consumer [163], have been found to be in particular supportive for the improvement of the user's sense of self. A service user said, *'To have others who say and show they believe in me, that I can achieve my goals, means the world to me'* [83]. In contrast, a clinical recovery approach in traditional psychiatry fosters low self-efficacy and self-stigma among users [84]. The trend must be turned around, and mental health services transformed into an empowerment service as suggested by the WHO [41]. One direction is to supplement traditional psychiatry with positive psychiatry and introduce a personal recovery approach, recovery-oriented services and measures for different populations of mental illness.

While much progress has been made, we still face the great challenge of continuing to explore and study the meaning of personal recovery and developing new valued and effective means and strategies to promote personal recovery, and implementing interventions that research has shown to be effective more successfully and widely. However, there are critical implementation components at organizational, performance and education levels that will need to be addressed to advance the transition of mental health services [72,164,165]. To agree on recovery policies and goals within an organization, as well as having recovery champions and service users involved at all levels in the organization, may be one way to support a sustainable change. For a positive psychiatry, multidisciplinary teams in which professionals attend to users' social, housing, educational, employment and well-being needs, as well as medical treatment needs, is essential, as in Assertive Community Treatment (ACT) teams [59], or the more flexible version of FACT [73]. When looking at the advancements of introducing personal recovery into mental health services, the concept and practice of recovery colleges need to be addressed, which focus on education instead of therapy. In the UK National Health Service, for example, there are several recovery colleges provided. They are delivered by professionals in mental health services, in partnership with persons who have lived experiences of mental health challenges [166]. Colleges are built on the national policy, and drive to create a society where people with mental health problems have access to the same life opportunities as anyone else. The idea is that students can learn and understand their resources and difficulties and develop self-management strategies. Families, carers and professionals may also attend courses. The introduction of recovery colleges may thus be one strategy to promote positive psychiatry in mental health services. Report findings show promising results. About 70% of the students find work, studies or voluntary work in mainstream settings after attending recovery colleges [167].

Since the purpose of the present overview was to introduce readers to the concept of personal recovery and discuss the potential and importance of ROS and measures, the literature review was not comprehensive or performed in a systematic manner [32]. Rather, it collects some of the central literature in order to illustrate the personal recovery construct, and related services and outcomes. In such an overview, it is inevitable that the authors' own views and orientation have an impact on the content and construction of the material. Nevertheless, two quality indicators was used in the review process, that all research or literature tapped mental disorder and personal recovery, and that known articles could be found among the hits. This kind of narrative literature review may be used to illuminate a broader topic of interest and may be performed by fewer reviewers (authors). Furthermore, such a review we believe can serve as a prelude to a systematic literature review.

Conclusions

The conceptualization of positive psychiatry and personal recovery has common features, as addressed in our present review. However, while positive psychiatry targets a larger population of persons who have or are at risk of developing mental illness [1,4], research within personal recovery has mainly focused on those with severe mental illness [39]. Furthermore, while the concept of positive psychiatry departs from theory of positive psychology [4], the underpinnings of personal recovery have emanated from the stories of consumers' journey and subsequently the research which

attempts to to capture this phenomena over the years. These diverse evolutions and understandings of mental health and well-being have perhaps reached a melting point, of rich knowledge that could help inform the transition from a traditional psychiatry, with a clinical recovery perspective only, towards a more positive psychiatry for all. In line with Jeste and colleagues, more work is needed but perhaps the process has begun [1].

Disclosure statement

No potential conflict of interest was reported by the authors.

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