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Review article

Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis

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Background
No systematic review and narrative synthesis on personal recovery in mental illness has been undertaken.

Aims
To synthesise published descriptions and models of personal recovery into an empirically based conceptual framework.

Method
Systematic review and modified narrative synthesis.

Results
Out of 5208 papers that were identified and 366 that were reviewed, a total of 97 papers were included in this review. The emergent conceptual framework consists of: (a) 13 characteristics of the recovery journey; (b) five recovery processes comprising: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (giving the acronym CHIME); and (c) recovery stage descriptions which mapped onto the transtheoretical model of change. Studies that focused on recovery for individuals of Black and minority ethnic (BME) origin showed a greater emphasis on spirituality and stigma and also identified two additional themes: culturally specific facilitating factors and collectivist notions of recovery.

Conclusions
The conceptual framework is a theoretically defensible and robust synthesis of people's experiences of recovery in mental illness. This provides an empirical basis for future recovery-oriented research and practice.

Declaration of interest
None.

Personal recovery has been defined as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles . . . a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness'.[1] A recovery orientation is mental health policy in most Anglophone countries. For example, the mental health plan for England 2009–2019 has the 'expectation that services to treat and care for people with mental health problems will be . . . based on the best available evidence and focused on recovery, as defined in discussion with the service user'.[2] The implications of a recovery orientation for working practice are unclear, and guidelines for developing recovery-oriented services are only recently becoming available.[3,4] Comprehensive reviews of the recovery literature have concluded that there is a need for conceptual clarity on recovery.[5,6] Current approaches to understanding personal recovery are primarily based on qualitative research[7] or consensus methods.[8] No systematic review and synthesis of personal recovery in mental illness has been undertaken.

The aims of this study were (a) to undertake the first systematic review of the available literature on personal recovery and (b) to use a modified narrative synthesis to develop a new conceptual framework for recovery. A conceptual framework, defined as 'a network, or a plane, of interlinked concepts that together provide a comprehensive understanding of a phenomenon or phenomena',[9] provides an empirical basis for future recovery-oriented research and practice.

Method

Eligibility criteria

The review sought to identify papers that explicitly described or developed a conceptualisation of personal recovery from mental illness. A conceptualisation of recovery was defined as either a visual or narrative model of recovery, or themes of recovery, which emerged from a synthesis of secondary data or an analysis of primary data. Inclusion criteria for studies were:

(a) contains a conceptualisation of personal recovery from which a succinct summary could be extracted;

(b) presented an original model or framework of recovery;

(c) was based on either secondary research synthesising the available literature or primary research involving quantitative or qualitative data based on at least three participants;

(d) was available in printed or downloadable form;

(e) was available in English.

Exclusion criteria were:

(a) studies solely focusing on clinical recovery[4] (i.e. using a predefined and invariant 'getting back to normal' definition of recovery through symptom remission and restoration of functioning);

(b) studies involving modelling of predictors of clinical recovery;

(c) studies defining remission criteria or recovery from substance misuse, addiction or eating disorders;

(d) dissertations and doctoral theses (because of availability).

Search strategy and data sources

Three search strategies were used to identify relevant studies: electronic database searching, hand-searching and web-based searching.

Electronic database searching

Twelve bibliographic databases were initially searched using three different interfaces: Applied and Complimentary Medicine

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Database (AMED); British Nursing Index; EMBASE; MEDLINE; PsycINFO; Social Science Policy (accessed via OVID SP); CINAHL; International Bibliography of Social Science (accessed via EBSCOhost); Applied Social Science Index and Abstracts (ASSIA); British Humanities Index; sociological abstracts; and Social Services abstracts (accessed via CSA Illumina). All databases were searched from inception to September 2009 using the following terms identified from the title, abstract, keywords or medical subject headings: ('mental health' OR 'mental illness$' OR 'mental disorder' OR mental disease' OR 'mental problem') AND 'recover$' AND ('theor$' OR 'framework' OR 'model' OR 'dimension' OR 'paradigm' OR 'concept$'). The search was adapted for the individual databases and interfaces as needed. For example, CSA Illumina only allows the combination of three 'units' each made up of three search terms at any one time, for example ('mental health' OR 'mental illness*' OR 'mental disorder') AND 'recover*' AND ('theor$' OR 'framework' OR 'concept'). As a sensitivity check, ten papers were identified by the research team as highly influential, based on number of times cited and credibility of the authors (included papers 3, 9, 10, 19, 29, 34, 35, 40, 68 and 75 in online Table DS1). These papers were assessed for additional terms, subject headings and key words, with the aim of identifying relevant papers not retrieved using the original search strategy. This led to the use of the following additional search terms: ('psychol$ health' OR 'psychol$ illness$' OR 'psychol$ disorder' OR psychol$ problem' OR 'psychiatr$ health', OR psychiatr$ illness$' OR 'psychiatr$ disorder' OR 'psychiatr$ problem') AND 'recover$' AND ('theme$' OR 'stages' OR 'processes'). Duplicate articles were removed within the original database interfaces using Reference Manager Software Version 11 for Windows.

Hand-searching

The tables of contents of journals which published key articles (*Psychiatric Rehabilitation Journal*, *British Journal of Psychiatry* and *American Journal of Psychiatry*) and recent literature reviews of recovery (included papers 4, 37 and 89 in online Table DS1) were hand-searched.

Web-based searching

Web-based resources were identified by internet searches using Google and Google Scholar and through searching specific recovery-oriented websites (Scottish Recovery Network: www.scottishrecovery.net; Boston University Repository of Recovery Resources: www.bu.edu/cpr/repository/index.html; Recovery Devon: www.recoverydevon.co.uk; and Social Perspectives Network: www.spn.org.uk).

Data extraction and quality assessment

One rater (V.B.) extracted data and assessed the eligibility criteria for all retrieved papers, with a random subsample of 88 papers independently rated by a second rater (J.W. or C.L.B.). Disagreements between raters were resolved by a third rater (M.L.). Acceptable concordance was predefined as agreement on at least 90% of ratings. A concordance of 91% was achieved. Data were extracted and tabulated for all papers rated as eligible for the review.

Included qualitative papers were initially quality assessed by three raters (V.B., J.W. and C.L.B.) using the RATS (relevance, appropriateness, transparency, soundness) qualitative research review guidelines.[10] The RATS scale comprises 25 questions about the relevance of the study question, appropriateness of qualitative method, transparency of procedures, and soundness of interpretive approach. In order to make judgements about quality of papers, we dichotomised each question to yes (1 point) or no (0 points), giving a scale ranging from 0 (poor quality) to 25 (high quality). A random subsample of ten qualitative studies were independently rated using the RATS guidelines by a second rater (M.L.). The mean score from rating 1 was 14.8 and from rating 2 was 15.1, with a mean difference in ratings of 0.3 indicating acceptable concordance. The Effective Public Health Practice Project (EPHPP)[11] quality assessment tool for quantitative studies was used to rate the two quantitative studies. Independent ratings were made by two reviewers (V.B. and M.L.) of Ellis & King[12] and Resnick *et al*,[13] who agreed on rating both papers as moderate.

Data analysis

The conceptual framework was developed using a modified narrative synthesis approach.[14] The three stages of the narrative synthesis comprised: (1) developing a preliminary synthesis; (2) exploring relationships within and between studies; and (3) assessing the robustness of the synthesis. For clarity, the development of the conceptual framework (Stages 1 and 3) is presented in the Results before the subgroup comparison (Stage 2).

Stage 1: developing a preliminary synthesis

A preliminary synthesis was developed using tabulation, translating data through thematic analysis of good-quality primary data, and vote counting of emergent themes. For each included paper, the following data were extracted and tabulated: type of paper, methodological approach, participant information and inclusion criteria, study location, and summary of main study findings. An initial coding framework was developed and used to thematically analyse a subsample of qualitative research studies with the highest RATS quality rating (i.e. RATS score of 15 or above), using NVIVO QSR International qualitative analysis software (Version 8) for Windows. The main overarching themes and related subthemes occurring across the tabulated data were identified, using inductive, open coding techniques. Additional codes were created by all analysts where needed and these new codes were regularly merged with the NVIVO master copy, and then this copy was shared with other analysts, so all new codes were applied to the entire subsample.

Finally, once the themes had been created, vote counting was used to identify the frequency with which themes appeared in all of the 97 included papers. The vote count for each category comprised the number of papers mentioning either the category itself or a subordinate category. On completion of the thematic analysis and vote counting, the draft conceptual framework was discussed and refined by all authors. Some new categories were created, and others were subsumed within existing categories, given less prominence or deleted. This process produced the preliminary conceptual framework.

Stage 2: exploring relationships within and between studies

Papers were identified from the full review which reported data from people from Black and minority ethnic (BME) backgrounds. These papers were thematically analysed separately, and the emergent themes compared with the preliminary conceptual framework. The thematic analysis utilised a more fine-grained approach, in which a second analyst (V.B.) went through the papers in a detailed and line-by-line manner. The aim of the subgroup analysis was to specifically identify any additional themes as well as any difference in emphasis placed on areas of the preliminary framework. Thus, our purpose was to identify areas of different emphasis in this subgroup of studies, not to perform a validity check.

Stage 3: assessing robustness of the synthesis

Two approaches were used to assess the robustness of the synthesis. First, qualitative studies which were rated as moderate quality on the RATS scale (i.e. RATS score of 14) were thematically analysed until category saturation was achieved. The resulting themes were then compared with the preliminary conceptual framework developed in Stages 1 and 2. Second, the preliminary conceptual framework was sent to an expert consultation panel. The panel comprised 54 advisory committee members of the REFOCUS Programme (see www.researchintorecovery.com for further details) who had academic, clinical or personal expertise about recovery. They were asked to comment on the positioning of concepts within different hierarchical levels of the conceptual framework, identify any important areas of recovery which they felt had been omitted and make any general observations. The preliminary conceptual framework was modified in response to these comments, to produce the final conceptual framework.

Results

The flow diagram for the 97 included papers is shown in Fig. 1 and online Table DS1 lists those papers that were included.

The 97 papers comprised qualitative studies ($n=37$), narrative literature reviews ($n=20$), book chapters ($n=7$), consultation documents reporting the use of consensus methods ($n=5$), opinion pieces or editorials ($n=5$), quantitative studies ($n=2$), combining of a narrative literature review with personal opinion or where there is insufficient information on method for a judgement to be made ($n=11$), and elaborations of other identified papers ($n=10$). In summary, 87 distinct studies were identified. The ten elaborating papers included in the thematic analysis but not in the vote counting were papers 11, 15, 16, 19, 26, 48, 50, 53, 71 and 73 in online Table DS1.

The 97 papers described studies conducted in 13 countries, including the USA ($n=50$), the UK ($n=20$), Australia ($n=8$) and Canada ($n=6$). Participants were recruited from a range of settings, including community mental health teams and facilities, self-help groups, consumer-operated mental health services and supported housing facilities. The majority of studies used inclusion criteria that covered any diagnosis of severe mental illness. A few studies only included participants who had been diagnosed with a specific mental illness (e.g. schizophrenia, depression). The sample sizes in qualitative data papers ranged from 4 to 90 participants, with a mean sample size of 27. The sample sizes in the two quantitative papers were 19[12] and 1076.[13] The former was a pilot study of 15 service users with experience of psychotic illness and 4 case managers using the Recovery Interventions Questionnaire, carried out in Australia. The latter study analysed data from two sources, the Schizophrenia Patient Outcomes Research Team (PORT) client survey, which examined usual care in a random sample of people with schizophrenia in two US states, and an extension to this survey which provided a comparison group.

There were various approaches to determining the stage of recovery of participants. Most studies rated stage of recovery using criteria such as: the person defined themselves as 'being in recovery'; not hospitalised during the previous 12 months; relatively well and symptom free; providing peer support to others; or working or living in semi-independent settings. Only a few studies specifically used professional opinion – clinical judgement or scores on clinical assessments – about whether people had recovered.

The mean RATS score for the 36 qualitative studies was 14.9 (range 8–20). One qualitative study was not rated using the RATS guidelines because there was insufficient information on methodology within this paper. A RATS score of 15 or above, indicating high quality, was obtained by 16 papers and used to develop a preliminary synthesis. A RATS score of 14, indicating moderate quality, was obtained by five papers. Independent ratings were made of the two quantitative papers, Ellis & King[12] and Resnick *et al*,[13] which were rated as moderate by two reviewers (V.B. and M.L.). Given this quality assessment, no greater weight was put on the quantitative studies in developing the category structure.

Conceptual framework for personal recovery

A preliminary conceptual framework was developed, which comprised five superordinate categories: values of recovery, beliefs about recovery, recovery-promoting attitudes of staff, constituent processes of recovery, and stages of recovery.

The robustness of the synthesis underpinning the preliminary conceptual framework was assessed in two steps: by re-analysing a subsample of qualitative studies and through expert consultation.

Subsample re-analysis

In addition to the higher-quality qualitative studies analysed in the preliminary synthesis stage, an additional five moderate-quality

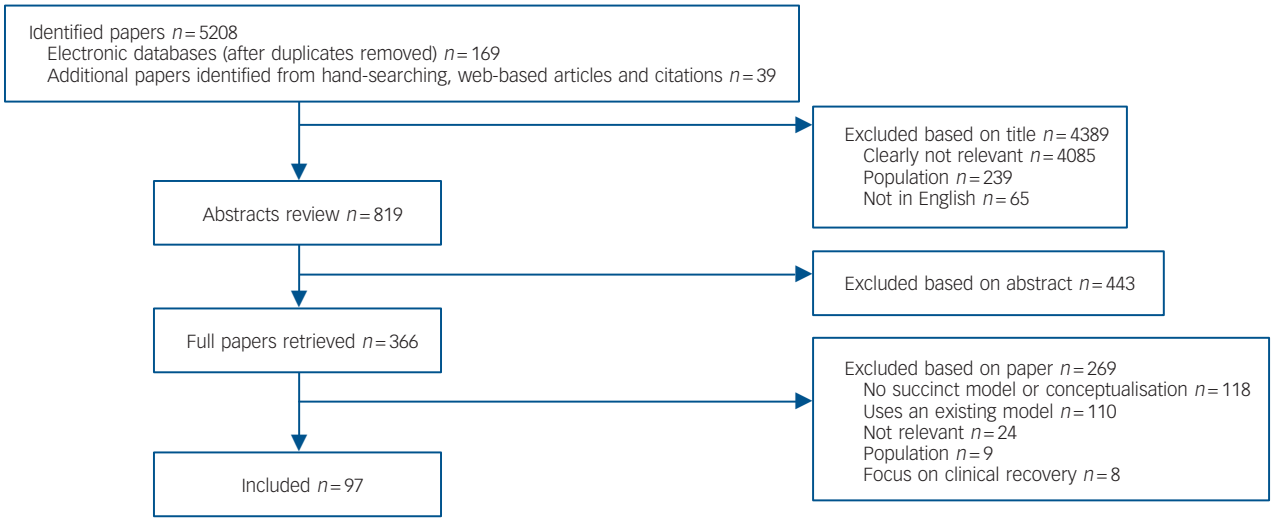

Fig. 1 Flow chart to show assessment of eligibility of identified studies.

(RATS score of 14) qualitative studies were analysed, which confirmed that category saturation had been achieved, indicating that the categories are robust.

Expert consultation

A response was received from 23 (43%) of the 54 consulted experts with international and national academic, clinical, and/or personal expertise and experiences of recovery, who are advisory committee members of the REFOCUS programme into recovery. Responses were themed under the following headings: conceptual (dangers of reductionism, separating processes from stages, confusing critical impetus for behaviours with actual behaviour, limitations of stage models); structural (complete omissions, lack of emphasis or overemphasis on specific areas of recovery); language (too technical); and bias (potential geographical bias). In response to this consultation, the preliminary conceptual framework was simplified, so the final conceptual framework now has three rather than five superordinate categories. Some subcategories were repositioned within recovery processes, and some category headings changed. Some responses identified areas of omission, such as the role of past trauma, hurt and physical health in recovery. However, no alteration was made to the conceptual framework as these did not emerge from the thematic analysis. Other points regarding the strengths and limitations of the framework are addressed in the Discussion. Overall, the expert consultation process provided a validity check on content of conceptual framework, although we were careful not to make radical changes which would have been unjustified, given the weight of evidence provided from preliminary analysis of the included papers.

The final conceptual framework comprises three interlinked, superordinate categories: characteristics of the recovery journey; recovery processes; and recovery stages.

Characteristics of the recovery journey were identified in all 87 studies, and vote-counting was used to indicate their frequency (Table 1).

The categories of recovery processes and their vote counts, indicating frequency of the process being identified, for the two highest category levels are shown in Table 2.

The full description of recovery processes categories and the vote counting results are shown in online Table DS2.

Table 1 Characteristics of the recovery journey

Characteristics	Number (%) of 87 studies identifying the characteristics
Recovery is an active process	44 (50)
Individual and unique process	25 (29)
Non-linear process	21 (24)
Recovery as a journey	17 (20)
Recovery as stages or phases	15 (17)
Recovery as a struggle	14 (16)
Multidimensional process	13 (15)
Recovery is a gradual process	13 (15)
Recovery as a life-changing experience	11 (13)
Recovery without cure	9 (10)
Recovery is aided by supportive and healing environment	6 (7)
Recovery can occur without professional intervention	6 (7)
Trial and error process	6 (7)

Fifteen studies developed recovery stage models. The studies were organised using the transtheoretical model of change,[15] as shown in Table 3.

Recovery in individuals of BME origin

As part of Stage 2 of the narrative synthesis process, six studies of recovery from the perspective of individuals of BME origin were identified within the 87 studies. These six studies were re-analysed by a second analyst (V.B.), using a more fine-grained, line-by-line approach to thematic analysis. These comprised a survey of 50 recipients of a community development project in Scotland,[16] a qualitative interview study of African Americans,[17] a narrative literature review,[18] a qualitative study of 40 Maori and non-Maori New Zealanders,[19] a pilot study to test whether the Recovery Star measure was applicable to Black and Asian ethnic minority populations[20] and a mixed method study of 91 males from African–Caribbean backgrounds.[21] These papers provide some preliminary insights into a small number of distinct ethnic minority perspectives, which do not represent a culturally homogeneous group, although some similarities in experience can be observed. Although these six papers were included in the vote-counting process, four of the six BME papers[16–18,20] were not used in the first-stage thematic analysis. The line-by-line secondary analysis allowed us to explore in greater detail any differences in emphasis and additional themes present in these papers.

The main finding of the subgroup analysis indicated that there was substantial similarity between studies focusing on ethnic minority communities and those focusing on ethnic majority populations. All of the themes of the conceptual framework were present in all six of the BME papers. Despite this overall similarity, there was a greater emphasis in the BME papers on two areas in the recovery processes: spirituality and stigma; and two additional

Table 2 Recovery processes

Recovery processes	Number (%) of 87 studies identifying the process
Category 1: Connectedness	75 (86)
Peer support and support groups	39 (45)
Relationships	33 (38)
Support from others	53 (61)
Being part of the community	35 (40)
Category 2: Hope and optimism about the future	69 (79)
Belief in possibility of recovery	30 (34)
Motivation to change	15 (17)
Hope-inspiring relationships	12 (14)
Positive thinking and valuing success	10 (11)
Having dreams and aspirations	7 (8)
Category 3: Identity	65 (75)
Dimensions of identity	8 (9)
Rebuilding/redefining positive sense of identity	57 (66)
Overcoming stigma	40 (46)
Category 4: Meaning in life	59 (66)
Meaning of mental illness experiences	30 (34)
Spirituality	6 (41)
Quality of life	57 (65)
Meaningful life and social roles	40 (46)
Meaningful life and social goals	15 (17)
Rebuilding life	19 (22)
Category 5: Empowerment	79 (91)
Personal responsibility	79 (91)
Control over life	78 (90)
Focusing upon strengths	14 (16)

Table 3 Recovery stages mapped onto the transtheoretical model of change

Table DS1 study number	Precontemplation	Contemplation	Preparation	Action	Maintenance and growth
32		Novitiate recovery – struggling with disability		Semi-recovery – living with disability	Full recovery – living beyond disability
73	Stuck	Accepting help	Believing	Learning	Self-reliant
3	Descent into hell	Igniting a spark of hope	Developing insight/ activating instinct to fight back	Discovering keys to well-being	Maintaining equilibrium between internal and external forces
44	Demoralisation		Developing and establishing independence		Efforts towards community integration
36	Occupational dependence		Supported occupational performance	Active engagement in meaningful occupations	Successful occupational performance
14	Dependent/unaware	Dependent/aware		Independent/aware	Interdependent/aware
29	Moratorium	Awareness	Preparation	Rebuilding	Growth
78		Glimpses of recovery	Turning points	Road to recovery	
61		Reawakening of hope after despair	No longer viewing self as primarily person with psychiatric disorder	Moving from withdrawal to engagement	Active coping rather than passive adjustment
40	Overwhelmed by the disability		Struggling with the disability	Living with the disability	Living beyond the disability
35	Initiating recovery			Regaining what was lost/moving forward	Improving quality of life
59	Crisis (recuperation)		Decision (rebuilding independence)	Awakening (building healthy interdependence)	
43		Turning point	Determination		Self-esteem

categories: culture-specific factors and collectivist notions of recovery.

In relation to spirituality, being part of a faith community and having a religious affiliation was seen as an important component of an individual's recovery. People from ethnic minority groups more often described spirituality in terms of religion and a belief in God as a higher power, whereas participants in the non-BME studies tended to conceptualise spirituality as encompassing a wider range of beliefs and activities.

In relation to stigma, BME studies emphasised the stigma associated with race, culture and ethnicity, in addition to the stigma associated with having a mental illness. Furthermore, being an individual from a minority ethnic group seemed to accentuate the stigma of mental illness, as the person often viewed themselves as belonging to multiple stigmatised and disadvantaged groups. Individuals from ethnic minority groups saw themselves as recovering from racial discrimination, stigma and violence, and not just from a period of mental illness.

The new category of culture-specific factors included the use of traditional therapies and faith healers, and belonging to a particular cultural group or community. Finally, collectivist notions of recovery were emphasised as both positive and negative factors. Many individuals discussed the hope and support they received from their collectivist identity, but for others the community added to the pressures of mental illness. This was particularly true where communities lacked information and awareness regarding mental illness. Furthermore, the negative impact of the community was felt not only at the level of the individual, but also at the collectivist level, with the whole family being adversely affected by stigma.

Discussion

This is the first systematic review and narrative synthesis of personal recovery. A conceptual framework was developed using a narrative synthesis which identified three superordinate categories: characteristics of the recovery journey, recovery processes and recovery stages. For each superordinate category, key dimensions were synthesised. The recovery processes that have the most proximal relevance to clinical research and practice are: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (giving the acronym CHIME). The robustness of the category structure was enhanced by the systematic nature of the review, the quality assessment of included studies, the category saturation reached in the analysis, and the content validity of the expert consultation. Heterogeneity between studies was explored descriptively. A subgroup comparison between the experiences of recovery from the perspective of individuals of BME origin identified similar themes, with a greater emphasis on spirituality and stigma, and two additional themes: culture-specific factors, and collectivist notions of recovery.

Implications for research and practice

Key knowledge gaps have been identified as the need for clarity about the underpinning philosophy of recovery,[22] better understanding of the stages and processes of recovery,[5] and valid measurement tools.[23] This study can inform each of these gaps.

Recovery has been conceptualised as a vision, a philosophy, a process, an attitude, a life orientation, an outcome and a set of outcomes.[5] This has led to the concern that 'its scope can make a cow-catcher on the front of a road train look discriminating'.[24] An empirically based conceptual framework can bring some order to this potential chaos. Characteristics of the recovery journey provide conceptual clarity about the philosophy. Recovery processes can be understood as measurable dimensions of change, which typically occur during recovery and provide a taxonomy of recovery outcomes.[25] Finally, recovery stages provide a framework for guiding stage-specific clinical interventions and evaluation strategies.

The framework contributes to the understanding about stages and processes of recovery in two ways. First, it allows available

evidence to be more easily identified. A recovery orientation has overlap with the literature on well-being,[26] positive psychology[27] and self-management,[28] and systematic reviewing is hampered by the absence of relevant MeSH (Medical Sub-Headings) headings relating to recovery concepts. The coding framework provides keywords for use when undertaking secondary research, and the identification of related terms provides a taxonomy which will be useable in reviews.

Second, the framework provides a structure around which research and clinical efforts can be oriented. The relative contribution of each recovery process, investigating interventions which can support these processes, and the synchrony between recovery processes and stages are all testable research questions. For clinical practice, the CHIME recovery processes support reflective practice. If the goal of mental health professionals is to support recovery then one possible way forward is for each working practice to be evaluated in relation to its impact on these processes. This has the potential to contribute to current debates about recovery and, for example, assertive outreach,[29] risk[30] and community psychiatry.[31]

Finally, the conceptual framework can contribute to the development of measures of personal recovery. Compendia of existing measures have been developed,[32,33] showing that the conceptual basis of measures is diverse. The conceptual framework provides a foundation for developing standardised recovery measures, and is the basis for a new measure currently being developed by the authors to evaluate the contribution of mental health services to an individual's recovery. The challenge will then be to incorporate a focus on recovery outcomes and associated concepts such as well-being[27] into routine clinical practice.[34]

Limitations

The study has three methodological and two conceptual limitations. The first methodological limitation is that the narrative synthesis approach was modified, and could have been widened. For example, the exploration in Stage 2 of relationships between studies could have considered the subgroup of studies which had higher levels of consumer involvement in their design, but it proved impossible to reliably rate identified studies in this dimension. The second technical limitation is that the emergent categories were only one way of grouping the findings, and the categories changed as a result of expert consultation. In particular, the three superordinate categories are not separate, since processes clearly occur within the identified stages, and the characteristics of recovery describe an overall movement through stages of recovery. Our categorical separation brings structure, but a replication study may not arrive at the same overall thematic structure. The final technical limitation is that analysis synthesised the interpretation of the primary data in each paper rather than considering the primary data directly. Future research could compare papers generated by different stakeholder groups, such as consumer researchers, clinical researchers and policy makers.

The first conceptual limitation is that this review, although synthesising the current literature on personal recovery, should not be seen as definitive. A key scientific challenge is that the philosophy of recovery gives primacy to individual experience and meaning ('idiographic' knowledge), whereas mental health systems and current dominant scientific paradigms give prominence to group-level aggregated data ('nomothetic' knowledge).[4] The practical impact is that current recovery research is primarily focused at the bottom of the hierarchy of evidence.[35] This was our finding, with qualitative, case study and expert opinion methodologies dominating. A motivator for the current study was to provide evidence of the form viewed as high quality within the current scientific paradigm, but several of our expert consultants highlighted the dangers of closing down discourse. Since recovery is individual, idiosyncratic and complex, this review is not intended to be a rigid model of what recovery 'is'. Rather, it is better understood as a resource to inform future research and clinical practice. The second conceptual limitation relates to the subgroup analysis looking at papers focusing on non-majority populations. Owing to a lack of research, it was not possible to look at the experience and perspectives of individuals from different ethnic minority groups. Therefore, the BME subgroup represents a heterogeneous and incredibly diverse set of populations. However, it was felt that all the populations included in these papers shared a common experience of belonging to an ethnic minority group, and that this experience may have important implications for the meaning of personal recovery, and for the experience of mental health services in general. The lack of data, coupled with the areas of difference found in the present review, highlights a need for further work to be conducted with people from ethnic minority communities.

Future research

This systematic review and narrative synthesis has highlighted the dominance of recovery literature emanating from the USA. Culturally, the USA neglects character strengths such as patience and tolerance,[36] and favours individualistic over collectivist understandings of identity. Although there were very few studies which looked at recovery experiences of individuals from BME backgrounds, the subsample of BME studies indicated that there are important differences in emphasis. There is a need for research involving more diverse samples of people from different ethnic and cultural backgrounds, at differing stages of recovery and experiencing different types of mental illness.

The complexity of personal recovery requires a range of theoretical inquiry positions. This review focused on research into first-person accounts of recovery, where individual meanings of recovery have dominated. This has led to a framework which may underemphasise the importance of the wider socio-environmental context, including important aspects such as stigma and discrimination. Viewing recovery within an ecological framework, as suggested by Onken and colleagues,[35] encompasses an individual's life context (characteristics of the individual such as hope and identity) as well as environmental factors (such as opportunities for employment and community integration) and the interaction between the two (such as choice). A more complete understanding of recovery requires greater attention to all these levels of understanding, for instance, how power is related to characteristics of individuals or groups (e.g. race and culture), how clinicians and patients interact at different stages of recovery and how these interactions change over time. There is also a need for future research to increase our understanding of how subtle micro-processes of recovery are operating, such as how hope is reawakened and sustained.

Supporting recovery processes may be the future mental health research priority. The 13 dimensions identified as characteristics of the recovery journey capture much of the experience and complexities of recovery, and further research may not have a high scientific pay-off. Similarly, although the recovery stages could be mapped onto the transtheoretical model of change,[15] there was little consensus about the number of recovery phases. It may therefore be more helpful to undertake evaluative research addressing specific service-level questions (such as whether people using a service are making recovery gains over time[37] or in different service settings[38]), rather than further studies seeking conceptual clarity. Overall, the emergent priority

is the development and evaluation of interventions to support the five CHIME recovery processes. The subordinate categories point to the need for a greater emphasis on assessment of strengths and support for self-narrative development, promoting the role of mental health systems in developing inclusive communities enabling access to peer support as well as providing retreats, and clinical interaction styles which promote empowerment and self-management. The CHIME categories are potential clinical end-points for interventions, in contrast to the current dominance of clinical recovery end-points such as symptomatology or hospitalisation rates. They also provide a framework for empirical investigation of the relationship between recovery outcomes, using methodologies developed in relation to clinical outcomes.[39] This area of enquiry is currently small[40] but an important priority if potential trade-offs between desirable outcomes are to be identified.[41]

Orienting mental health services towards recovery will involve system transformation.[42] The research challenge is to develop an evidence base which simultaneously helps mental health professionals to support recovery and respects the understanding that recovery is a unique and individual experience rather than something the mental health system does to a person. This conceptual framework for personal recovery, which has been developed through a systematic review and narrative synthesis, provides a useful starting point for meeting this challenge.

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19 Lapsley H, Nikora LW, Black R. *Kia Mauri Tau! Narratives of Recovery from Disabling Mental Health Problems*. Mental Health Commission, 2002.

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EXTRA CONTENT ONLINE

poems by doctors

Street-wise

Wendy French

Somewhere in a North London street near Northwick Park
a retired doctor pins his butterflies, worries about sex.

Elsewhere in the street a siren stops outside
a two-up, two-down where paramedics collect
a woman with a fluttering heart.

Somewhere in an East London street near the London
a young doctor revising for her MRCP dreams of take-aways,

Chicken Biriyani, Tarka Dal.
Elsewhere a man dials 999, he doesn't want to die.
Whisky half drunk and paracetamol gone.

Somewhere in a South London street near King's
a woman gazes into the gas fire, thinks about her husband

and the locum who came at 3am, drank tea.
His own father recently dead and his mother who keeps
all doors unlocked for her husband's return.

Elsewhere near UCH a woman's contractions
Increase as she phones her partner, he's not at his desk

so the neighbour drives her as fast as he can and leaves her
to the student on duty who comforts her between groans.
The partner enjoys a light lunch. Pint of pride.

Somewhere in a London street a man comes near to dying.
His car skids sideways on ice. Approaching cars close in.

He thinks after one death there is no other.
A stranger helps him shuffle along
until stillness returns.

In the same street the old doctor remembers climbing
the snow-ridden hills, a bride by his side and he still feels

her bracelets, purse, red felt hat.
And there's his grandson with Down's who loves to touch velvet,
collect stamps and who lives in a home on a West London street

where the Hammersmith closes. Wards full of flu-ridden adults.
Next door to the doctor little Louise in the wheelchair

drinks orange through a straw, cries throughout the night.
The physician turns back to his moth, the Bloodvein,
a splayed sacrifice and sighs.

This poem is from *The Hippocates Prize 2011*, published by The Hippocrates Prize in association with Top Edge Press.

Chosen by Femi Oyebode.

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Table DS1 Included studies (*n*=97)

	Full reference	Country	Method	Quality rating
1	Provencher H, Gregg R, Mead S, Mueser K. The role of work in the recovery of persons with psychiatric disabilities, *Psychiatr Rehab. J*, 2002, **26**(2), 132-144.	USA	Semi-structured individual interviews (n=14 participants with psychiatric disabilities)	13/25
2	Kelly M, Gamble C. Exploring the concept of recovery in schizophrenia, *J Psychiatr Ment Health Nurs.* 2005 Aug;**12**(4):386.	Unclear	Literature review	Not rated
3	Noiseux S, Ricard N. Recovery as perceived by people with schizophrenia, family members and health professionals: A grounded theory. *Int. J of Nurs. Studies*, 2008, **45** (8), 1148-1162	Canada	Semi-structured interviews and field notes (n=41 people with schizophrenia, family members and health professionals)	18/25
4	Social Care Institute for Excellence, A common purpose: Recovery in future mental health services, 2007.	UK	Literature review	Not rated
5	Schon UK, Denhov A, Topor A. Social relationships as a decisive factor in recovering from severe mental illness, *Int. J of Soc Psychiatry*, 2009, **55** (4) 336-347.	Sweden	Interviews (n=58 people who had recovered from serious mental illness)	13/25
6	Smith M. Recovery from severe psychiatric disability: Findings of a qualitative study, *Psychiatr Rehab. J*, 2000, **24** (2), 149-158	USA	Semi-structured interviews (n=10 participants with serious mental illness)	13/25
7	Tooth B, Kalyanasundaram V, Glover H, Momenzadah S. Factors consumers identify as important to recovery from schizophrenia, *Australasian Psychiatry*, 2003, **11**(1), 70-77.	Australia	Focus groups (n=57 people in recovery from schizophrenia)	12/25
8	Libermann R, Kopelowicz A, Ventura J, Gutkind D. Operational criteria and factors related to recovery from schizophrenia, *Int. Review of Psychiatry*, 2002a.**14**(4), 256-272.	USA	Literature review, focus groups, case vignettes of people recovering from schizophrenia	Not rated
9	Ramon S, Healy B, Renouf N. Recovery from Mental Illness as an Emergent Concept and Practice in Australia and the UK, *Int.. J. Soc Psychiatry*, **53**, 108-122.	UK and Australia	Literature review	Not rated
10	Mancini MA. A qualitative analysis of turning points in the recovery process, *American J of Psychiatr Rehab.*, 2007, **10**(3), 223-244.	USA	Semi-structured interviews (n=16 participants recovering from serious psychiatric disability)	13/25
11	Mezzina R, Davidson L, Borg M, Marin I, Topor A, Sells D. The social nature of recovery: Discussion and implications for practice, American J of Psychiatr Rehab.. 2006, 9(1), 63-80.	Italy and USA	Literature review and conceptual paper	Not rated
12	Fallot R. Spiritual and religious dimensions of mental illness recovery narratives, *New directions for mental health services*, **80**, Winter, 1998.	Unclear	Personal narratives and literature review	Not rated
13	Morse G. On being homeless and mentally ill: A multitude of losses and the possibility of recovery, chapter 16, in Harvey J & Miller E (Eds). *Loss and trauma: General and close relationship perspectives*. New York, US: Brunner-Routledge, 2000	Unclear	Personal narratives and literature review	Not rated
14	*Emerging best practices in mental health recovery,* National Institute for Mental Health in England., Great Britain. National Health Service, 2004.	UK	Based on Ohio Department of Mental Health work on the meaning and process of recovery.	Not rated
15	Piat M, Sabetti J, Couture A, Sylvestre J, Provencher H, Botschner J, Stayner D. What does recovery mean for me? Perspectives of Canadian mental health consumers, *Psychiatr Rehab. J*, 2009, **32**(3), 199-207.	Canada	Qualitative interviews (n= 60 consumers of mental health services)	18/25

16	Davidson L, O'Connell M, Staeheli M, Weingarten R, Tondora J, Evans A. Concepts of recovery in Behavioral health: History, review of the evidence, and critique, in Davidson L, Rowe M, Tondora J, O'Connell M, Lawless M, *A practical guide to recovery-oriented practice*. Oxford. Oxford University Press, 2009.	USA	Literature review	Not rated
17	Diamond R. Recovery from a psychiatrist's viewpoint, *Postgraduate Medicine*, 2006, **Sept.** Special, 54-62	Unclear	Literature review	Not rated
18	Gagne C, White W, Anthony W. Recovery: A common Vision for the fields of mental health and addiction, *Psychiatr Rehab. J*, 2007, **31**(1), 32-37.	USA	Literature review	Not rated
19	Davidson L, O'Connell M, Tondora J, Lawless M, Evans A. Recovery in Serious Mental Illness: A New Wine or Just a New Bottle? *Professional Psychology: Research and Practice*, **36** (5), 480-487	USA	Literature review and concept map	Not rated
20	Davidson L, O'Connell M, Staeheli M, Weingarten R, Tondora J, Evans A A model of being in recovery as a foundation for recovery-oriented practice, in Davidson L, Rowe M, Tondora J, O'Connell M, Lawless M *A practical guide to recovery-oriented practice*. Oxford. Oxford University Press, 2009.	USA	Interviews (n=100 consumers and people who have lived with mental illness)	Not rated
21	Slade M. 'Recovery-focussed mental health services: The personal recovery framework', in *Personal recovery and mental illness: A guide for mental health professionals*, Cambridge University Press, 2009.	UK	Literature review	Not rated
22	Repper J, Perkins R. 'The individual's recovery journey: towards a model for mental health practice, in Repper, J. & Perkins, R. *Social inclusion and recovery: a model for mental health practice*, Bailliere Tindall, 2003.	UK	Literature review	Not rated
23	Markowitz FE. Sociological Models of Recovery, chapter 4, in Ralph, R. & Corrigan, P. *Recovery in mental illness: Broadening our understanding of wellness*. Washington, DC, US: American Psychological Association, 2005.	USA	Literature review	Quality not assessed
24	Ralph R. Verbal Definitions and Visual Models of Recovery: Focus on the Recovery Model, in Ralph R, Corrigan P. *Recovery in Mental illness: Broadening our understanding and wellness*, Washington, DC, US: American Psychological Association, 2005.	USA	Literature review	Not rated
25	Libermann RP, Kopelowicz A. Recovery from schizophrenia: A challenge for the 21st century, *Int. Review of Psychiatry*, 2002, 14(4) 245-255.	USA	Literature review	Not rated
26	Libermann R, Kopelowicz A. Open forum. Recovery from schizophrenia: a concept in search of research, *Psychiatr Services*, 2005, **56**(6), 735-742	USA	Literature review	Not rated
27	Whitehorn D, Brown J, Richard J, Rui Q, Kopala L Multiple dimensions of recovery in early psychosis, Int. Review of Psychiatry, 2002, 14(4), 273-283.	Canada	Literature review	Not rated
28	Ellis G, King R. Recovery focused interventions: Perceptions of mental health consumers and their case managers. *Australian e-J for the Advancement of Ment. Health*, 2003, **2**(2).	Australia	Literature review and piloting of a consumer and case manager questionnaire	Not rated
29	Andresen R, Oades L, Caputi P. The experience of recovery from schizophrenia: towards an empirically validated stage model, *Australian & New Zealand J of Psychiatry*, 2003, **37**(5), 586-594.	Australia	Literature review and qualitative analysis	Not rated
30	Torrey W, Wyzik, P. The recovery vision as a service improvement guide for community mental health center providers. *Community Ment. Health J*, 2000, **36** (2):209-216.	USA	Opinion piece	Not rated
31	Cleary A, Dowling M. The road to recovery, *Ment. Health Practice*, 2009, **12**(5), 28-	Ireland	Literature review	Not rated

	31.			
32	Song L-Y, Shih C-Y. Factors, process and outcome of recovery from psychiatric disability the utility model, *Int. J of Social Psychiatry*, 2009, **55**(4), 348-360.	Taiwan	Qualitative interviews (n=15 consumers in recovery and their caregivers)	15/25
33	Resnick S, Fontana A, Lehman A, Rosenheck R. An empirical conceptualization of the recovery orientation, *Schizophrenia Research*, 2005, **75**, 119-128.	USA	Survey on the treatment of schizophrenia (n=1,076)	Not rated
34	Jacobson N. Experiencing recovery: A dimensional analysis of recovery narratives, *Psychiatr Rehab. J* 2001 Winter; **24**(3):248-56.	USA	Dimensional analysis of 30 narratives of recovery.	Not rated
35	Young S, Ensing D. Exploring recovery from the perspective of people with psychiatric disabilities, *Psychiatr Rehab. J*, 1999, **22**(3), 219-231.	USA	Semi-structured interviews (n= 18 people with psychiatric disabilities) and focus groups (n=2, 11 participants in total)	15/25
36	Merryman M, Riegel S. The recovery process and people with serious mental illness living in the community: An occupational therapy perspective, *Occupational Therapy in Ment. Health*. 2007, **23**(2), 51-73.	USA	Interviews (n=20 service users)	16/25
37	Ralph R. Recovery, *Psychiatr Rehab. Skills*, 2000, **4**(3), 480-517.	USA	Literature review	Not rated
38	Jensen L, Wadkins T. Mental health success stories: finding paths to recovery, *Issues in Ment. Health Nurs.*, 2007, **28**(4), 325-340.	USA	Semi-structured interviews (n=20 service users)	13/25
39	Schrank B, Slade M. Recovery in psychiatry, *Psychiatr Bulletin*, 2007, **31**(9), 321-325.	Austria, UK	Literature review	Not rated
40	Spaniol S, Wewiorski N, Gagne C, Anthony W. The process of recovery from schizophrenia, *Int. review of psychiatry*, 2002, **14**, 327-336.	USA	Interviews (n=12 consumers, conducted every four to eight months, over a 4 year period)	16/25
41	Mental Health Recovery Study Working group, *Mental Health 'Recovery': users and refusers. What do psychiatric survivors in Toronto think about Mental Health Recovery*? Wellesley Institute, 2009.	Canada	Community-based participatory research approach., focus groups (n=7)	Not rated
42	Hopper K. Rethinking social recovery in schizophrenia: what a capabilities approach might offer, *Social Science and Medicine*, 2007, **65**(5), 868-879.	USA	Literature review	Not rated
43	Peden A. Recovering in depressed women: research with Peplau's theory. *Nurs Sci Q*, 1993, **6**(3), 140-146	USA	Semi-structured interviews (n= 7 participants recovering from depression)	14/25
44	Bradshaw W, Armour M, Roseborough D. Finding a place in the World: The experience of Recovery from Severe Mental Illness, Qual. Social Work, 2007, 6(1), 27-47. Sage Publications, UK.	USA	Semi-structured interviews (n= 45 with severe mental illness, conducted over 3 years)	18/25
45	Sung K, Kim S, Puskar K, Kim E. Comparing Life Experiences of College Students with Differing Courses of Schizophrenia in Korea: Case Studies Perspectives in Psychiatric Care, 2006, 42(2), 82-94.	South Korea	In-depth interviews (n= 8 people diagnosed with schizophrenia)	17/25
46	NHS Scotland, Finding strength from within, Report on three local projects looking at mental health and recovery with people from some of black and minority ethnic communities in Edinburgh, 2008.	Scotland	Exploratory community development project (n= 50 people from BME communities with personal experience of recovery)	Not rated
47	Ajayi S, Billsborough J, Bowyer T, Brown P, Hicks A, Larsen J, Mailey P, Sayers R, Smith R. Getting back into the world: Reflections on lived experiences of recovery, *Rethink recovery series: 2.,* 2009.	UK	Interviews (n=48 people with personal experience of mental illness)	18/25
48	Connecticut Department of Mental Health Addiction Services: Proposed model of mental health recovery and recovery-oriented services, in Davidson L, Rowe M, Tondora J, O'Connell M, Lawless M, *A practical guide to recovery-oriented practice*. Oxford. Oxford University Press, 2009.	USA	Position paper	Not rated

49	Mancini A. Self-determination theory: A framework for the recovery paradigm, *Adv. in Psychiatr Treatment*.2008, **14**(5),358-365.	USA	Literature review	Not rated
50	Armour M, Bradshaw W. Roseborough D. African Americans and recovery from severe mental illness, *Social Work in Ment. Health*, 2009, **7(**6), 602-622.	USA	Semi-structured interviews (n=9 African-American with serious and persistent mental illness, conducted with each participant 3 times)	11/25
51	Davidson L, Andres-Hyman R, Bedregal L, Tondora J, Fry J, Kirk T. From 'Double trouble to Dual recovery': Integrating models of recovery in addiction and mental health, *J of Dual Diagnosis*, **4**(3), 2008, 273-290.	USA	Literature review and consultation (n=45 people with addictions or in recovery from serious mental illness.	8/25
52	Sullivan W. A long and winding road: The process of recovery from severe mental illness, in Spaniol L, Gagne C, Koehler M, (eds) *Psychological and social aspects of Psychiatr disabilities*, Boston University Center, 1997.	USA	Semi-structured interviews (n=46 current and former service users)	13/25
53	Mancini M. Consumer-providers' theories about recovery from serious psychiatric disabilities, chapter 2, from Rosenberg, *Community Mental Health: Challenges for the 21st Century, Routledge,* 2006.	USA	Semi-structured interviews (n==15 people diagnosed with a psychiatric disability who also provide peer-support services to others)	11/25
54	Ridge D, Ziebland S. "The old me could never have done that": how people give meaning to recovery following depression, Qual. Health Research, 2006, 16(8), 1038-1053.	UK	Open-ended interviews (n=38 people who have had depression)	CHECK RATS
55	Sydney West Area Health Service, (2008) Maintaining wellness and promoting recovery, sections 4-6, in *The wellness guide – a resource to support the recovery journey*, March 2008.	Australia	Part of a Wellness Guide developed in partnership between consumers and clinicians.	
56	Armstrong N, Steffen J. The Recovery Promotion Fidelity Scale: Assessing the organizational promotion of recovery, *Community Ment. Health J*, 2009, **4**5(3), 163-170.	USA	Literature review and concept mapping (n= 5 focus groups) and survey	16/25
57	Noordsy D, Toeey W, Mueser K, O'Keefe C, Fox L. Recovery from severe mental illness: an intrapersonal and functional outcome definition, *Int. Review of Psychiatry*, 2002, **14**, 318-326.	USA	Focus groups and observation	Not rated
58	Forchuk C, Jewell J, Tweedell D, Steinnage IL. Reconnecting the client experience of recovery from psychosis, *Perspectives in Psychiatr Care*, 2003, **39** (4) 141-150.	Canada	Interviews and observation (n=10 patients over the initial year of treatment with clozapine or risperidone)	16/25
59	Baxter E, Diehl S. Emotional stages: Consumers and family members recovering from the trauma of mental illness, *Psychiatr Rehab. J*, 1998, **21**(4), 349-355.	USA	Interviews (n=40 consumers)	11/25
60	Oades L, Deane F, Crowe T, Lambert W, Kavanagh D, Lloyd C. Collaborative recovery: An integrative model for working with individuals who experience chronic and recurring mental illness. *Australasian Psychiatry*, 2005, **13**(3), 279-284.	Australia	Multi-site study in 9 organisations	Not rated
61	Glover H. Lived experience perspectives, in *Handbook of psychosocial rehabilitation*, King R, Lloyd C, Meehan T, Wiley-Blackwell, 2007.	Australia	Literature review and personal narrative	Not rated
61	Ridgeway P. Re-Storying psychiatric disability: Learning from first person recovery narratives, *Psychiatr Rehab. J*, 2001, **24**(4), 335-343	USA	Grounded theory analysis of 4 existing 'seminal' narratives	17/25
63	Bonney S, Stickley T. Recovery and mental health: A review of the British literature, *J of Psychiatr and Ment. Health Nurs*., 2008, **15**(2), 140-153.	UK	Literature review	Not rated
64	Mead S, Copeland M. What recovery means to us: Consumers' perspectives,	USA	Personal narratives and opinion piece	8/25

	Community Ment. Health J, 2000, **36**(3), 315-328.			
65	Sowers W. Transforming systems of care: the American Association of Community Psychiatrists guidelines for recovery oriented services, *Community Ment. Health J*, 2005, **41**(6), 757-774	USA	Literature review	Not rated
66	Plum K. How patients view recovery: what helps, what hinders, *Archives of Psychiatr Nurs.,* 1987, **1**(4), 285-293.	USA	Analysis of narratives (n=20)	13/25
67	Ahern L, Fisher D. Recovery at your own PACE (Personal Assistance in Community existence). *J of Psychosocial Nurs. & Ment. Health Services*, 2001, **39**(4), 22-32.	USA	Literature review and qualitative research	Not rated
68	Jacobson N, Curtis L. Recovery as policy in mental health services: Strategies emerging from the states, *Psychiatr Rehab. J*, 2000, **23**(4), 333-341.	USA	Literature review	Not rated
69	Lunt A. A theory of recovery. *J of Psychosocial Nurs. & Ment. Health Services*, 2002, **40** (12), 32-39.	USA	Literature review and opinion piece	Not rated
70	Nicholls V. *Feeding the flowers: SPN perspective on recovery*, 2007.	UK	Literature review and qualitative research	Not rated
71	Ralph R, Risman J, Kidder, K. *The Maine contingent of the recovery advisory group*, May, 1999.	USA	Personal narratives and literature review	6/25
72	Mental Health Providers Forum, *The recovery star model*, 2008.	UK	Measure development	Not rated
73	Mental health providers forum*, The recovery star model and cultural competency*, BAME Pilot Report, 2009.	UK	Pilot study to test measure with BME population	Not rated
74	Brown M, Essien P, Etim-Ubah P et al. *Report of the community led research project focussing on male African and African Caribbean perspectives on recovery*, Southside Partnership Fanon, 2008.	UK	Semi-structured interviews and questionnaires (n=91)	20/25
75	Mancini M, Hardiman E, Lawson H. Making Sense of It All: Consumer Providers' Theories about Factors Facilitating and Impeding Recovery from Psychiatric Disabilities, *Psychiatr Rehab. J*, 2005, **29**(1), 48-55.	USA	Semi-structured interviews (n=15 adults recovering from serious psychiatric disability and leading consumer provision of mental health services)	14/25
76	Bradstreet S, Brown W. Elements of recovery: Int. learning and the Scottish context, *SRN Discussion Paper Series* Report **No. 1.** 2004.	UK	Literature review	Not rated
77	Jacobson N, Greenley D. (2001) What is recovery? A conceptual model and explication. *Psychiatr Services*, **52** (4), 482-485.	USA	Synthesis of consumer narratives	Not rated
78	Lapsley H, Waimarie Nikora L, Black R. *Kia Mauri Tau! Narratives of recovery from disabling mental health problems*. Report of the University of Waikato Mental Health Narratives Project. Wellington: Mental Health Commission, 2002.	New Zealand	Interviews (n=40 who once had a disabling mental health problem)	20/25
79	Jenkins J, Carpenter-Song E. The new paradigm of recovery from schizophrenia: cultural conundrums of improvement without cure, *Culture, Medicine and Psychiatry*, 2006, **29**(4), 379-414.	USA	Interviews (n=90 people attending community out-patient clinics)	18/25
80	Barton R. The rehabilitation-recovery paradigm: A statement of philosophy for a public mental health system, *Psychiatr Rehab. Skills*, 1998, **2**(2), 171-187.	USA	Literature review	Not rated
81	Spaniol L, Gagne C, Koehler M. The recovery framework in rehabilitation and mental health, chapter 4, in Moxley, D. & Finch, J. *Sourcebook of rehabilitation and mental health practice*. New York, US: Kluwer Academic/Plenum, 2003.	USA	Literature review	Not rated
82	Glover H. Recovery based service delivery: Are we ready to transform the words into a paradigm shift? *Australian e-J for the Advancement of Ment. Health*, 2005, **4**(3), 1-4.	Australia	Opinion piece	Not rated

83	Irish Mental Health Commission. *A recovery approach within the Irish mental health services: A framework for development*, 2008.	Ireland	Literature review	Not rated
84	Ochocka J, Nelson G, Janzen R. Moving Forward: Negotiating Self and External Circumstances in Recovery, *Psychiatr Rehab. J*, 2005, **28**(4), 315-322.	Canada	In-depth interviews (n=28 people who had experienced serious mental health problems)	14/25
85	Brown W. The possibility of wellness, *Ment. Health Today*, 2007, **Sept.** 23-26.	Scotland	Semi-structured interviews (n=64)	12/25
86	Steen M. Essential structure and meaning of recovery from clinical depression for middle-adult women: a phenomenological study*, Issues in Ment. Health Nurs.*, 1996, **17**(2), 73-92.	USA	Interviews (n=22 participants with clinical, unipolar depression)	13/25
87	Fisher D. Healthcare reform based on an empowerment model of recovery by people with psychiatric disabilities, *Hospital and community psychiatry*, 1994, **45**(9), 913-915.	USA	Opinion paper	Not rated
88	Substance Abuse and Mental Health Service Administration, *National Consensus statement on mental health recovery*, 2004.	USA	Consensus methods (n= 110 expert panellists)	Not rated
89	Onken S, Craig C, Ridgway P, Ralph R, Cook J. An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatr Rehab. J*, **31**(1), 9-22. 2007	USA	Literature review	Not rated
90	Anthony W. Recovery from mental illness: The guiding vision of the mental health service system in the 1990s, *Psychosocial Rehab. J*, 1993, **16**(4), 11-23.	USA	Opinion piece and literature review	Not rated
91	Pitt L, Kilbride M, Nothard S, Welford M, Morrison A. Researching recovery from psychosis: a user-led project, *Psychiatr Bulletin*, 2007, **31**, 55 - 60.	UK	User-led interview study (n= 7 people in recovery)	19/25
92	Anderson B, Munchel W. *Opportunity on the doorstep: recovery-oriented leadership*, 2005 Village ISA and Community Activators, Inc.	USA	Opinion piece	Not rated
93	Borg M, Davidson, L. The nature of recovery as lived in everyday experience, *J of Ment. Health*, 2008, **17**(2), 129-140.	Norway	Interviews (n=13 individuals in recovery)	14/25
94	Asmundsdottir E. Creation of New Services: Collaboration Between Mental Health Consumers and Occupational Therapists, *Occupational Therapy in Ment. Health*, 2009, **25**(2), 115-126.	Iceland	Interviews and focus groups (n=25)	14/25
95	Davis E, Velleman R, Smith G, Drage M. Psychosocial developments: Towards a model of recovery, in Velleman R, Davies E, Smith G, & Drage M. (eds.) *Changing outcomes in Psychosis, Collaborative cases from practitioners, users and carers*, pp1-21., BPS Blackwell, 2006.	UK	Literature review	Not rated
96	Warren K. *Exploring the concept of recovery from the perspective of people with mental health problems*. Norwich School of Social Work and Psychosocial Studies, University of East Anglia, 2003.	UK	Literature review, narrative analysis, interviews	9/25
97	Piat M, Sabetti J, Bloom D. The importance of medication in consumer definitions of recovery from serious mental illness: A qualitative study, *Issues in Ment. health Nurs.*, 2009, **30**(8), 482-490.	Canada	Semi-structured interviews (n= 54 consumers of mental health services)	18/25

For full list of excluded studies, please contact Dr Mary Leamy (mary.leamy@kcl.ac.uk).

Table DS2 Vote counting of recovery processes

Recovery processes	Number (%) of 87 studies
Category 1: Connectedness	**75 (86%)**
1.1 Peer support and support groups	*39 (45%)*
1.1.1 Availability of peer support	22 (25%)
1.1.2 Becoming a peer support worker or advocate	17 (20%)
1.2 Relationships	*33 (38%)*
1.2.1 Building upon existing relationships	19 (22%)
1.2.2 Intimate relationships	9 (10%)
1.2.3 Establishing new relationships	8 (9%)
1.3 Support from others	*53(61%)*
1.3.1 Support from professionals	42 (48%)
1.3.2 Supportive people enabling the journey	27 (31%)
1.3.3 Family support	26 (30%)
1.3.4 Friends and peer support	18 (21%)
1.3.5 Active or practical support	4 (5%)
1.4 Being part of the community	*35 (40%)*
1.4.1 Contributing and giving back to the community	21 (24%)
1.4.2 Membership of community organisations	13 (15%)
1.4.3 Becoming an active citizen	11 (13%)
Category 2: Hope and optimism about the future	**69 (79%)**
2.1 Belief in possibility of recovery	*30 (34%)*
2.2 Motivation to change	*15 (17%)*
2.3 Hope-inspiring relationships	*12 (14%)*
2.3.1 Role-models	8 (9%)
2.3 Positive thinking and valuing success	*10 (11%)*
2.4 Having dreams and aspirations	*7 (8%)*
Category 3: Identity	**65 (75%)**
3.1 Dimensions of identity	*8 (9%)*
3.1.1 Culturally specific factors	7 (8%)
3.1.2 Sexual identity	2 (2%)
3.1.3 Ethnic identity	4 (5%)
3.1.4 Collectivist notions of identity	6 (7%)
3.2 Rebuilding/redefining positive sense of self	57 (66%)
3.2.1 Self-esteem	21 (24%)
3.2.2 Acceptance	21 (24%)

3.2.3 Self-confidence and self-belief	11 (13%)
3.3 Over-coming stigma	40 (46%)
3.3.1 Self-stigma	27 (31%)
3.3.2 Stigma at a societal level	32 (37%)
Category 4: Meaning in life	**59 (66%)**
4.1 Meaning of mental illness experiences	*30 (34%)*
4.1.1 Accepting or normalising the illness	22 (25%)
4.2 Spirituality (including development of spirituality)	*36 (41%)*
4.3 Quality of life	*57 (65%)*
4.3.1 Well-being	27 (31%)
4.3.2 Meeting basic needs	*18 (21%)*
4.3.3 Paid voluntary work or work related activities	19 *(22%)*
4.3.4 Recreational and leisure activities	8 (9%)
4.3.5 Education	7 (8%)
4.4 Meaningful social and life goals	*15 (17%)*
4.4.1 Active pursuit of previous or new life or social goals	15 (17%)
4.4.2 Identification of previous of new life or social goals	8 (9%)
4.5 Meaningful life and social roles	*40 (46%)*
4.5.1 Active pursuit of previous or new life or social roles	40 (46%)
4.5.2 Identification of previous of new life or social roles	34 (39%)
4.6 Rebuilding of life	*20 (23%)*
4.6.1 Resuming with daily activities and daily routine	12 (14%)
4.6.2 Developing new skills	8 (9%)
Category 5: Empowerment	**79 (91%)**
5.1 Personal responsibility	*79 (91%)*
5.1.1 Self-management	60 (69%)
Coping skills	25 (29%)
Managing symptoms	22 (25%)
Self-help	12 (14%)
Resilience	25 (29%)
Maintaining good physical health and well-being	12 (14%)
5.1.2 Positive risk-taking	17 (20%)
5.2 Control over life	78 (90%)
5.2.1 Choice	31 (36%)
Knowledge about illness	17 (20%)
Knowledge about treatments	7 (8%)
5.2.2 Regaining independence and autonomy	23 (26%)

5.2.3 Involvement in decision-making	23(26%)
Care planning	35 (40%)
Crisis planning	7 (8%)
Goal setting	12 (14%)
Strategies for medication	25 (29%)
Medication not whole solution	11 (13%)
5.2.4 Access to services and interventions	13 (15%)
5.3 Focussing upon strengths	*14 (16%)*

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