

Self-determination theory: a framework for the recovery paradigm[†]

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Abstract Recovery is an increasingly important concept in mental health services research and policy-making. However, despite burgeoning interest in the concept, no overarching theoretical or empirical framework has been offered to support its key ideas. Further, it is often unclear how recovery ideas translate into routine practices of mental health programmes and practitioners. In this article, a theoretical framework for recovery ideas is derived from self-determination theory, a widely researched and empirically validated theory of human need fulfilment. I discuss the conceptual overlap of self-determination theory and recovery ideas, and, using key motivational concepts, develop a typology of recovery-oriented practices for three hypothetical programme types (controlling, traditional/paternalistic and recovery oriented). I describe existing measures of recovery-oriented practice and consider the implications of self-determination theory for measurement of and research on recovery-oriented practice.

Notions of ‘recovery’ are exerting increasing influence on mental health services and policy-making across the globe. So widespread is this influence that recovery initiatives from government entities or advocacy groups can be found in virtually every country with a modern mental health system. Broad policy statements in the USA and the UK have advocated for a mental health system transformed in accord with recovery principles (New Freedom Commission on Mental Health, 2003; Scottish Executive, 2006). Given the extraordinary level of interest in the concept, one might expect to find clear definitions of recovery, a robust scientific recovery literature and validated methods for supporting recovery-oriented practices. In fact, recovery has taken on diverse meanings, sometimes sowing confusion among mental health policy makers, administrators and practitioners (Davidson *et al*, 2006). Furthermore, there is a near absence of empirical research on recovery, although this has begun to be remedied (e.g. Resnick *et al*, 2005). Finally, few efforts have been undertaken to identify organisational mental health practices that are conducive to and consistent with recovery.

In beginning to address these deficits, an important step is to put recovery on a firmer empirical and theoretical footing. One well-researched theoretical framework that can bear on our understanding

of recovery is self-determination theory (Ryan & Deci, 2000). A motivational theory that posits three fundamental human needs (autonomy, competence and relatedness to others), self-determination theory shows striking similarity to basic ideas on recovery (Onken, 2004). Thus, the goal of the present article is to consider the potential relevance of self-determination theory to programme development, theorising and research on recovery. Indeed, I argue here that self-determination theory can help to clarify what is meant by recovery, guide its measurement and furnish testable hypotheses that will further the scientific study of recovery.

Defining recovery

Ideas of recovery first emerged from landmark first-person accounts of mental illness in the 1970s (Davidson, 2003). Loosely allied to a burgeoning social movement, the consumer/survivor (or user/survivor) movement, these narratives traced highly personal journeys taken by people with mental illness in their effort to reclaim basic social roles and human rights. These narratives sought to define recovery in terms more expansive than the amelioration of symptoms. They often described recovery as necessarily self-defined and non-linear, maintaining that it will wax and wane over the course of a person’s life. Although these

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Box 1 Recovery themes

- *Identity formation*: mental illness is one facet of a more differentiated self
- *Autonomy/self-agency*: greater capacity for self-initiated action
- *Hope*: renewed sense of possibility
- *Supportive, healing relationships*: professional and personal
- *Enhanced role functioning*: employment, parenthood, etc.

early narratives, and many subsequent ones, each described a unique path to recovery, common themes have been identified (Jacobson & Greenley, 2001; Ridgway, 2001; Davidson, 2003). Box 1 shows my particular perspective on these themes. Although not exhaustive, these broad themes define basic internal and external conditions conducive to recovery.

After identifying basic components of recovery, the critical next step is to determine how mental health programmes can provide services specifically to further recovery. Theorists, researchers and consumer advocates have offered various formulations of 'recovery-oriented' practices (Anthony, 2000; New York State Consumers, 2003; Onken *et al.*, 2002). Although these conceptualisations differ to some degree, a common theme is the critical role of the external environment in facilitating the internal conditions of recovery. That is, recovery cannot be brought forth by sheer force of will; it must be facilitated by factors external to the person. Unfortunately, these facilitative conditions are typically in scarce supply for people with serious mental illness, in large measure because such illness puts them at risk of being in environments that are suboptimal for healthy functioning.

It can be argued that people with serious mental illness are uniquely subject to impersonal social forces, which, in their totality, may compromise functioning even when intended to be therapeutic. For example, they may be remanded to receive out-patient treatment, required to take medication to receive psychosocial services, given substandard housing away from family and among strangers, exposed to increased risk of arrest and incarceration, and involuntarily hospitalised.[‡] Such experiences are regrettably routine for people with serious mental illness, undermining their ability to act independently, furthering their isolation from others

[‡]Patient choice in compulsory detention has been the subject of a series of linked articles in *APT* (2008, 14(3)): see Roberts *et al.*, 172–180; Copeland & Mead, 181–182; Fulford & King, 183–184; Dorkins *et al.*, 184–186. Ed.

and complicating their resumption of ordinary social roles. Indeed, recovery narratives have amply documented the corrosive effects of involvement with systems of care and social control. Nevertheless, for many people with serious mental illness, the treatment setting, a part of the larger system of care, can be a source of genuine support and an important component of the recovery process.

How then do we identify aspects of treatment and mental health programmes that can ameliorate both the primary (e.g. symptoms) and secondary consequences (e.g. corrosive effects of system involvement) of serious mental illness and thus further a person's recovery? In considering this question, I propose that the principal secondary consequence of serious mental illness, the one that recovery ideas primarily address, is the loss of a sense of personal autonomy (for a discussion in *APT* of the philosophical dimensions of this issue, see Ikkos *et al.*, 2006). Ideas regarding autonomy are central to self-determination theory, which can therefore illuminate this critical aspect of mental health programmes and treatment.

Self-determination theory and recovery-oriented practice

Self-determination theory posits that human beings thrive and grow, achieve goals and feel greater well-being under conditions that support the fulfilment of basic human needs (Ryan & Deci, 2000). Through an extensive programme of empirical research, investigators have identified three underlying human needs that are fundamental to motivation and well-being (the need for autonomy, competence and relatedness to others). The theory posits that we all have an inherent tendency to fulfil these needs. However, social and other environments vary greatly in the degree to which they support the fulfilment of basic needs. A person's performance and well-being at work and at school, and their improvement and retention in treatment settings and in psychotherapy, have been shown to depend to a large degree on whether basic human needs are fulfilled (Ryan & Deci, 2000). By extension, the environment of the treatment setting, whether it supports or obstructs clients' autonomy, feelings of competence and relatedness to others, will significantly influence whether other desired outcomes are achieved. Essentially, all practices that have been deemed recovery-oriented address the basic needs outlined by self-determination theory.

Although each need is important, I would suggest that instilling a sense of autonomy is the *sine qua non* of recovery-oriented practice for at least three reasons. First, a feeling of autonomy is a basic condition for self-motivated behaviour, a critical component of

recovery and of well-being. Second, because serious mental illness may undermine and intermittently impair a person's ability to initiate desired behaviours and express preferences, the deliberate shoring up of this capability must be a basic aspect of treatment for such illness. Third, the routine infringements on autonomy that people with serious mental illness are subject to would likely further erode the sense of autonomy. Thus, inculcating a greater sense of autonomy through various components of treatment and the treatment environment is critical to the recovery of people with serious mental illness.

This perspective is supported by an extensive literature documenting the positive effects of 'autonomy-supportive' environments (for a review of this programme of research see Ryan & Deci, 2000). In nursing homes, for example, greater perceived support for autonomy (as opposed to control of behaviour) has been associated with greater well-being; in work settings, employees who reported greater satisfaction of needs for autonomy showed better performance and greater job satisfaction; in the management of illness, people with type 2 diabetes who perceived their care as more supporting of their autonomy showed better glycaemic control, and perceiving one's physician as more supportive of autonomy is associated with better adherence to medication regimens; in alcohol misuse treatment, more autonomous motivation for entering treatment is associated with greater involvement and greater retention in treatment; and in educational settings, greater support of autonomy (*v.* control) is associated with deeper processing, better test performance, more persistence and more autonomous learning processes. These findings have underscored the critical role of the environment in facilitating individuals' motivation to achieve desired outcomes.

Role of the treatment environment in enhancing motivation for recovery

Motivation is a critical component of recovery, one that has largely been ignored by researchers of serious mental illness. Self-determination theory's account of human motivation holds significant implications for mental health practice. Therefore, using the motivational framework of self-determination theory, I next consider the role of two overarching types of motivation: internal and external.

Internal motivation

Internal motivation refers to 'the inherent tendency to seek out novelty and challenges, to extend and exercise one's capacities, to explore, and to learn' (Ryan & Deci, 2000; p. 70) An internally motivated

activity is performed because of the pleasure and satisfaction of the activity itself. Such motivation reflects our highest human capacities, the need to explore, show curiosity, express interest and seek mastery. The achievement of internal motivation likely occurs as people progress to more advanced stages of recovery.

External motivation

Also relevant to recovery are the varieties of external motivation. Most broadly, external motivation refers to behaviours performed to achieve an external outcome, either the attainment of a reward or the avoidance of a sanction. Many behaviours, perhaps most in everyday life, are performed for external reasons. Nevertheless, even when our behaviours are externally motivated, there can be marked differences in the nature of that motivation. For example, a person with serious mental illness may take medication purely to comply with external pressures and contingencies or may take it out of a genuine belief that it is beneficial and will help them achieve other goals. In each case, the motivation is external. However, in the first instance, the person is performing the behaviour merely to mollify an external authority and avoid a negative consequence, whereas in the second, the person has embraced the goal and expressed personal choice. These distinct motivational orientations probably have significant consequences for future medication adherence and for feelings of autonomy and well-being.

The treatment environment

These motivational orientations do not occur in a vacuum. Mental health programmes play a basic role in promoting both internal and more salutary forms of external motivation. I would suggest that recovery-oriented practices are fundamentally concerned with how the fulfilment of basic needs can further recovery. A brief review of commonly identified recovery-oriented practices and themes underscores their relation to the basic needs identified by self-determination theory. For example, Anthony's (2004) suggestive idea of 'personhood' in recovery, which posits that 'people with psychiatric disabilities want the same things that most people want' resonates with self-determination theory's notion of fundamental human needs. Self-agency and choice, essential themes in recovery narratives and recovery-oriented practices, speak to the critical role of autonomy, which is a central tenet of self-determination theory. The role of employment and other social roles in the recovery process suggest that feelings of competence are a facet of recovery (Onken *et al.*, 2002). Finally, the importance of needs for relatedness is reflected in the emphasis on

community integration and social supports in recovery (Nelson *et al*, 2001). In sum, self-determination theory holds significant parallels to recovery-oriented practices, and its solid empirical base suggests that programmes that implement such practices to a greater extent are more likely to achieve better outcomes for clients than programmes that implement them to a lesser extent.

A typology of programmatic recovery-oriented practices

Given the essential parallels between self-determination theory and recovery-oriented practices, it behoves us to consider how the former might inform mental health practices. To achieve this goal, I propose three hypothetical programme types arrayed along a continuum of recovery-oriented practice. I describe these hypothetical programmes as controlling, traditional/paternalistic and recovery-oriented, and consider, in turn, their basic regulatory mechanisms, their clinical and organisational practices, and their potential impact on consumers' motivation and self-regulation. This typology is derived from the work of Ryan & Deci (2000) and is illustrated in Table 1. It describes hypothetical exemplars rather than actual programmes, which might blend aspects of each programme type.

Programme regulatory mechanisms

Mental health programmes can avail themselves of a variety of regulatory mechanisms to further the self-regulation of the people they serve. Indeed, it could be suggested that an implicit model of regulation is present in every aspect of programme functioning, including a programme's policies and procedures,

interventions, medication practices, documentation of services, care planning and guiding philosophy. In broad terms, then, how do programmes differ with respect to these regulatory mechanisms? I would submit that the critical difference is how and whether contingencies (rewards or sanctions) are used to manage client behaviour (Table 1). In a controlling programme, for example, the primary regulatory mechanism will be the threat of sanctions for behaviour viewed as undesirable. By their nature, sanctions orient the person to external requirements or expectations and promote externally motivated behaviour whose primary aim is to manage these sanctions. In their most extreme form, negative contingencies can be seen as manifestations of an implacable force beyond the person's control, resulting in feelings of total incompetence and absence of any motivation. Such internal states are obviously antithetical to a person's recovery.

By contrast, a recovery-oriented programme will often eschew contingencies when addressing client problems (although it is not possible or desirable to remove contingencies entirely) and instead attempt to regulate clients' behaviour through other means, eliciting their perspective on problems, enabling the expression of preferences and encouraging independent decision-making, even when these decisions may appear to be ill-advised. It can be argued that allowing clients to make mistakes and experience the consequences of those mistakes is a hallmark of recovery orientation. The deference given, moreover, to the clients' ability to make decisions promotes feelings of autonomy that are salutary and indeed necessary for recovery.

A middle ground between these extremes can be found in the traditional/paternalistic programme. Programmes of this type will typically employ

Table 1 Hypothetical continuum of recovery-oriented practice

	<i>Controlling</i>	<i>Traditional/paternalistic</i>	<i>Recovery-oriented</i>
<i>Programme regulatory mechanisms</i>			
Nature of contingencies	Punishment focus	Reward focus	Non-contingent
<i>Associated practices</i>			
Role of medication	Mandated	Emphasised	Integrated
Individualisation	Absent	Moderate	Robust
Care planning	Boilerplate	Symptom focus	External goal focus
Client <i>v.</i> clinician-driven	Programme-driven	Clinician-driven	Client-driven
Consumer feedback mechanisms	Absent	Pro forma	Basic to programme
Role of choice	Minimal	Circumscribed	Present in all aspects
Implicit treatment focus	Control of behaviour	Maintaining stability	Promoting recovery
<i>Impact on client's self-regulation</i>			
Motivational profile	Amotivation	External	Internal
Attitudes toward self	Feelings of incapability	Contingent self-worth	Self-determining
Autonomous functioning	Helplessness	Dependency	Degrees of independence
	Provider-determined		Client-determined

rewards to promote desired behaviour and will also adopt other strategies to some degree (e.g. for example, providing choice in relation to type of medication). Regulating clients' behaviour in this way will tend to reinforce feelings of dependency but will not induce feelings of total incompetence or amotivation. Although more benign than the controlling programme type, the paternalistic/traditional programme will typically discourage clients' independent action and risk-taking, often out of the fear that it will compromise their stability. The type of motivation that results from a reward focus is also primarily external. It is worth noting that an ample literature has demonstrated that external rewards diminish pleasure in activities and orient the person to the reward as opposed to the activity (Ryan & Deci, 2000). The regulatory mechanism in the traditional/paternalistic programme (the leveraging of rewards) is not designed to promote recovery; rather, it is designed to maintain stability and prevent deterioration.

Clinical and organisational practices

The regulatory mechanisms described above are associated with distinct clinical and organisational practices (Table 1). Consider one aspect of programme functioning: care planning. In a controlling programme such as in-patient psychiatric treatment, care plans are typically boilerplate documents that focus on processes of care and not the person's own needs or goals. For example, participation in treatment groups or medication adherence may be principal goals, making the goal of the care plan the treatment itself. This approach to care planning reinforces the programme and the treatment as an authority over the person, promoting external motivation and complicating the development of personally meaningful and internally motivated goals. In a recovery-oriented programme, by contrast, the preponderance of goals in the care plan would embody the person's own unique wishes and preferences as reflected in the external focus of goals (e.g. developing friendships outside of the programme, becoming involved in peer advocacy, finding independent housing). These goals would seek to push the individual outward and into the world and build on and develop the person's capacity for self-initiated action and internal motivation. This goal focus would likely further recovery by diminishing the person's dependence on the programme and enhancing their integration into the larger community. By contrast, the emphasis on outward activities as an appropriate goal of treatment is largely absent in traditional/paternalistic programmes, in which stabilisation is the primary focus of the care plan (i.e. reduction in symptoms, absence of relapse).

Another example can be found in the role of medication. A client who refuses to take medication in a controlling programme may face a variety of overt and implied negative consequences, including disapproval, supervised medication-taking, potential withdrawal of services, or even loss of housing. These sanctions would obviously reinforce the external authority of the programme and detract from the person's sense of responsibility for medication, increasing the likelihood of future non-adherence. By contrast, a recovery-oriented programme would eschew the use of any contingency, recognising the person's right to refuse medication. This would not preclude, however, discussion and exploration of the person's reasons for refusing medication and efforts to persuade them to reconsider. What is more, recovery-oriented programmes will tend to integrate medication into a larger treatment plan, as opposed to considering medication as the only effective intervention. A different strategy regarding medication would be evident in the traditional/paternalistic programme, which would typically seek to create incentives for medication-taking such as linking medication to privileges, disbursements of money or other rewards.

Client self-regulation

Each of these programme types – their regulatory approach and clinical and organisational practices – would have very different effects on their clients' self-regulation. The primary distinction drawn above is in the use of contingencies and their attendant effects on clients' capacity to develop and sustain more salutary forms of motivation. Programmes that adopt a controlling approach will have the most deleterious consequences for clients' motivation, producing adherence, helplessness, feelings of incompetence, and of not being valued. The traditional/paternalistic type will tend to promote behaviour that is less externally motivated but that none the less is focused on positive contingencies. Because recovery must involve a sufficient degree of motivation, this programme will typically not engage the person's internal motivation to recover. The recovery-oriented programme, by contrast, will result in greater self-valuing through incentives for independent behaviour and will tend to further the internalisation of life goals and the development of feelings of autonomy, necessary preconditions of recovery.

How can recovery-oriented programmes be supported? One way is through organisational assessment of recovery-oriented practices. Next I discuss a number of different approaches to measuring recovery-oriented practices, considering their potential role in policy development, research and quality improvement.

Measuring recovery-oriented practice

In contrast to office-based psychotherapy for conditions such as depression and anxiety disorders, treatment for severe mental illness typically occurs in the highly contextualised environment of a 'programme'. This programme milieu or environment has a variety of elements, many of which are not specifically designed or intended to have therapeutic effects (e.g. the warmth of the receptionist, documentation of services, location of toilets, rules of conduct, transportation to the programme). In traditional office-based psychotherapy, these factors are often peripheral or non-existent. However, in treatment programmes for severe mental illness, the non-therapeutic programme elements may be of equal or even of greater importance to the client than the therapeutic elements. Indeed, I would submit that it is the sum total of the programme – both therapeutic and non-therapeutic elements – that determines its effectiveness in promoting recovery. For this reason, it is not only whether, for example, evidence-based approaches to vocational rehabilitation are used but whether policies support clients' participation in programme operations, whether strengths-based care planning is used, or even perhaps whether clients and staff have access to the same toilet.

There are two primary methods for measuring recovery-oriented practice: organisation-level scales

(measured indirectly through assessment of practices, policies, documentation and so on) and self-report scales (directly administered to practitioners and administrators). The technology of organisation-level assessment has matured considerably in the past 10 years, spurred on by the evidence-based practice movement in mental health. Fidelity scales, which are organisation-level assessments of the degree to which an evidence-based practice has been faithfully implemented, have played an increasingly central role in mental health services research and policy-making in the USA (Bond *et al*, 2000). This work suggests that the fidelity scale methodology can be fruitfully applied to the measurement of organisational recovery-oriented practices.

An organisation-level scale

A colleague and I recently developed an organisational measure, the Recovery-Oriented Practices Index (ROPI; details available from author). Using a qualitative approach, we distilled broad categories of recovery-oriented practice from extant measures of recovery. We then used self-determination theory to help identify underlying principles of recovery-oriented practices (Box 2). The principles were then operationally defined using the methods of fidelity scales, including behavioural anchors that focused on a variety of programme functions (e.g. clinical practices, programme policies and documentation). Initial support for construct validity of this scale

Box 2 Principles of recovery-oriented practice

- *Meeting basic needs*: the assessment, planning and delivery of all services should first address basic needs
- *Comprehensive services*: a range of treatment services (medication, vocational, family-based, substance misuse, wellness, counselling, trauma) using different modalities (individual, group, peer) should be provided
- *Customisation and choice*: the planning and delivery of all services should be designed to address the unique circumstances, history, needs, expressed preferences and capabilities of each client
- *Client involvement and participation*: client involvement should be integral to the planning and delivery of all services and to the determination of policies and procedures for programme operations, including client employees who are hired with equality in pay, benefits, and responsibilities
- *Network supports/community integration*: Active efforts should be made in the planning and delivery of services to involve environmental supports in the client's recovery and to promote community integration
- *Strengths-based approach*: service delivery and planning should be fundamentally oriented towards client's strengths rather than deficits
- *Self-determination*: the development of autonomous motivation and feelings of self-agency should be integral to the planning and delivery of all services, with minimal reliance on coercive treatment
- *Recovery focus*: services should be oriented towards life roles, client aspirations and independence from services, including techniques for self-management of mental health symptoms, development of meaningful activities, and assistance with employment, parenthood and romantic relationships

was found in a significant correlation of a self-report measure of recovery orientation, the Recovery Self-Assessment Scale (O'Connell *et al*, 2005) and the overall ROPI score ($r=0.74, P<0.01$). This indicated that the ROPI scores were consistent with an alternate method of assessing recovery orientation. The ROPI is currently being used as an evaluation tool in New York state and Scotland (Scottish Executive, 2006), but further work is needed establish interrater reliability and to assess predictive validity (degree to which recovery orientation is associated with superior outcomes).

Self-report scales

As indicated, self-report measures of recovery-oriented practices and attitudes have also been developed. These include the Recovery Self-Assessment Scale (RSAS; O'Connell *et al*, 2005) and its companion instrument, the Recovery Knowledge Inventory (RKI; Bedregal *et al*, 2006). These scales assess the degree to which programme staff or administrators endorse practices and hold attitudes that have been identified as recovery oriented. The RSAS measures a variety of programme practices and policies, including whether practitioners elicit the preferences of participants, whether clients sit on advisory boards, and whether language associated with recovery is typically used. The focus of the RKI is on staff attitudes associated with recovery, including whether staff have high expectations for clients, believe in clients' taking risks to further recovery and believe that clients should determine their own treatment. Although research using these scales is scarce at this early stage, initial work has established a factor structure for the scales and provided some additional psychometric support (O'Connell *et al*, 2005; Bedregal *et al*, 2006). Aggregating practitioners' scores on these measures can provide a rough index of a programme's embrace of recovery-oriented practice and attitudes.

Another way to further the evolution of recovery-oriented practice is to measure practices that are derived from the principles of self-determination theory. For example, the basic distinction between autonomy support and control and between contingent and non-contingent interventions can be assessed through a variety of means (self-report measures, qualitative studies and organisational scales). Researchers of self-determination theory have developed a variety of measures that can be adapted to the measurement of mental health programmes and practitioners (for a list of measures and other material on self-determination theory, go to www.psych.rochester.edu/SDT/index.html). For example, the degree to which practitioners endorse autonomy-supportive *v.* autonomy-controlling interventions may bear on the degree to which they

practise in a recovery-oriented manner. Beliefs and attitudes of staff regarding the ability of clients to be self-determining might also influence their interventions or whether they work with clients in a collaborative manner.

Research on these constructs could link more generalised properties of programmes directly to client outcomes. In other words, programmes with practitioners that endorse more autonomy-supportive interventions and embrace more self-determining attitudes might well produce better outcomes for clients. But the absence of measurement instruments for these constructs has hindered research. Indeed, there is a glaring absence of outcome research in the study of recovery-oriented practices. Furthermore, given the controversies surrounding the use of coercion in the treatment of people with serious mental illness, research that can identify the consequences of coercion or provide more insight into the nature of coercion can only be beneficial.

Role in policy-making

The next important question is how recovery orientation can be furthered as a programme property and policy objective. One way is to develop assessment and feedback mechanisms for programme performance related to recovery orientation. Such mechanisms could be embedded in accreditation or certification of programmes, or other monitoring approaches. In New York state, for example, a licensed programme type was developed for assertive community treatment, a community-based model of care for serious mental illness (New York State Office of Mental Health, 2008). To support faithful implementation, programme standards for the treatment were incorporated into routine monitoring, with programmes expected to meet those standards. A similar approach could be used for recovery orientation, promulgating programme standards and developing monitoring processes to assess adherence to the standards. However, one difficulty with this approach is that external monitoring of standards can be experienced as punitive and can be applied inflexibly. The promotion of recovery orientation should be consistent with its animating ideas, namely, support for the autonomous functioning not just of individuals but of mental health programmes. Therefore, an alternate approach is advocacy, seeking to create awareness of recovery-oriented practices and to promote dialogue about how to implement them. This approach is supported by a recent study I conducted with a colleague in which we found that psychiatrists with more awareness of recovery concepts were more likely to employ recovery-oriented practices (Ranz & Mancini, 2008).

Conclusions

As these recent efforts, and many others, attest, recovery and recovery-oriented practices are not a passing fad. Aided by the internet and growing networks of client advocates, ideas of recovery have gained such currency that it is now impossible to speak of system-level change without invoking them. But although the prescriptions of recovery are gradually being absorbed by practitioners, administrators and policy makers, it remains unclear how to develop and support such practices. An urgent research priority is to focus greater attention on the specific characteristics of recovery-oriented programmes and recovery-oriented practitioners and optimal methods for supporting them.

Declaration of interest

None.

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MCQs

1 Self-determination theory:

- proposes that everyone is capable of determining their own life
- advances the critical role of one's ideas about the self
- maintains that there are fundamental human needs common to us all
- advocates for a transformed mental health system
- overlooks our capacity for self-motivation.

2 According to self-determination theory, the three basic human needs are:

- autonomy, self-esteem and respect
- autonomy, competence and self-esteem
- competence, respect and self-esteem
- relatedness to others, respect and self-esteem
- autonomy, competence and relatedness to others.

3 The process of recovery:

- is largely the same for everyone
- occurs in a linear fashion
- is unique for each person
- can only occur with the help of professionals
- is a function of will power.

4 A basic goal of recovery-oriented practice is to:

- stabilise the condition of people with mental illness
- maintain adherence to medication regimens
- promote autonomy and community integration
- locate appropriate housing
- reduce symptoms.

5 A controlling programme type is likely to:

- mandate medication
- solicit the opinions of clients
- use a client-centred approach
- avoid contingencies in managing client behaviour
- emphasise community integration.

MCQ answers

1	2	3	4	5
a F	a F	a F	a F	a T
b F	b F	b F	b F	b F
c T	c F	c T	c T	c F
d F	d F	d F	d F	d F
e F	e T	e F	e F	e F