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PERSPECTIVE

# Psychiatry and/or recovery: a critical analysis

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**ABSTRACT:** *This perspective paper aims to present a personal viewpoint on the impact of psychiatric discourse on the principles of recovery in mental health care. Mental health services espouse these principles, yet psychiatric discourse remains the dominant model. A critical analysis will examine how psychiatry maintains this dominance. The aim is to examine how psychiatric discourse constructs both the nature of mental distress and its treatment, and how it maintains its power as the dominant authority and its relationship to recovery principles. The paper concludes that psychiatric discourse is the antithesis of recovery principles and that its authority is perpetuated through co-opting a medical explanatory model, claiming expertise in the ability to predict social risk, and maintaining a tightly controlled echo chamber. A way forward involves the dismantling of the hierarchical service delivery model based on psychiatric discourse and replacing it with a more horizontal service delivery model in which the lived experience of mental distress is central. Regular audit of services needs to prioritize recovery principles. The implications for mental health nursing are considered.*

**KEY WORDS:** *critical analysis, nursing, recovery.*

## AIM

This perspective paper aims to present a personal viewpoint on the impact of psychiatric discourse on the implementation of principles of recovery in mental health services.

## BACKGROUND

This perspective paper was prompted by a question that has concerned me for some time: After two decades, why is it that recovery principles have had a minimal impact on the way mental health services are delivered and the care available to those experiencing mental distress? Other studies have identified a struggle to implement recovery principles in a psychiatric setting because of the power imbalance and psychiatric dominance (Cleary *et al*. 2018; Orjasaeter & Almvik 2022; Otte *et al*. 2020), but the processes that perpetuate this have not been previously explored.

Governments around the world espouse recovery principles in the delivery of mental health care (Australian Government National Mental Health Commission 2017; Department of Health 2021; Mental Health Commission of Canada 2012; Ministry of Health 2021). However, there is an expectation they be integrated into the existing culture of mental health services. Institutions responsible for mental health service delivery espouse the importance of recovery principles, and medical and nurse education incorporates recovery-focused modules, but there is little evidence of this in everyday clinical practice.

There have been 55 high-profile public inquiries relevant to mental health held over the last 30 years. Despite an enormous effort by the community generally, and by people with experience of mental health care specifically, to effect change in the mental health sector through formal inquiry processes, key recommendations for mental health care 30 years ago remain current issues today (Francis *et al*. 2022). The World Health Organization Report on Mental Health (World Health Organization 2022) also identifies nothing much has changed in the past 30 years and that mental health

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systems and services remain ill-equipped to meet people's needs. The latest New Zealand review identified that despite the current levels of investment, psychiatric services are not delivering the required outcomes, and even when they respond to people with a mental illness, they do so through 'too narrow a lens' (He Ara Oranga p.11). An Australian review (Commonwealth of Australia 2015) identified that service delivery is based on the needs of providers, rather than on consumer choice and a 'one size fits all' approach to service delivery that does not optimally match or meet individual needs. These reviews all point to ongoing and serious problems in the delivery of mental health services.

## METHOD

The principles of recovery will be briefly described to provide a basis for later comparison with psychiatric discourse. This will be followed by a critical analysis of how psychiatric discourse obtained its power and influence, and the strategies used to maintain and reproduce this. The questions directing this analysis will be:

1. Why has there been little change in the way mental health services are delivered despite ongoing recommendations for change?
2. What strategies are used to enable psychiatric discourse to maintain and reproduce its dominance and authority?
3. What effect does psychiatric discourse have on the practice of recovery principles?
4. How does psychiatric discourse compare with recovery principles in relation to ontological positions, aetiological positions, evidence base, focus, nature of the relationship, therapeutic task, and prognosis?

### Design

This perspective paper aims to examine why recovery principles are often peripheral and not integral in mental health services by critically analysing psychiatric discourse, particularly the strategies employed to maintain its dominance. Critical analysis acknowledges that contemporary structures and practices have a historical basis and that individual and cultural behaviour, practices, and beliefs are framed and influenced by historical and structural factors. Psychiatric discourse is not about individual psychiatrists but rather is a particular set of values, knowledge, and beliefs that determines what can happen in practice.

Discourses shape how we understand ourselves and others and how we act about this. Fairclough (1992) outlined three ways in which the constructive effects of discourse are evident: they contribute to the construction of subject positions (socially acceptable ways of being in the world); they construct social relationships between people; and they contribute to the construction of systems of knowledge and belief (e.g. psychiatry). To maintain dominance, there are particular discursive strategies to ensure its reproduction.

### Recovery principles

Recovery has been defined as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles and a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness (Anthony 1993). It provides an approach to mental distress that places the whole person with lived experience at the centre. The emphasis is not on a reduction of the person to a set of symptoms but is holistic and cooperative (Llewellyn-Beardsley *et al*. 2019). Human behaviour is interactive and inextricable from its social and cultural context. The meaning of behaviours can only be understood in this context (Middleton & Moncrieff 2018).

The principles of recovery have been described by the American Psychological Association consensus statement that included 'patients, health-care professionals, researchers, and others (American Psychological Association 2012) as self-direction, individualized and person-centred care, empowerment, and participation in decision-making, holistic, non-linear, strengths-based, peer support, respect, responsibility, and hope. A key conceptual framework for describing recovery that has similar principles (Leamy *et al*. 2011) involves connectedness, hope, optimism, identity, meaning and purpose, and empowerment. A sense of control over one's life, a sense of self-mastery, and realization of adaptive capacity have been identified as core elements of recovery (Kerr *et al*. 2020). Damsgaard *et al*. (2021) identified loneliness, isolation, and being seen as equivalent to their diagnosis as an obstruction to recovery, causing doubt as to who they were as a person.

The generalizability of the concept of recovery remains a concern in relation to non-Western cultures (Slade *et al*. 2014). It has been noted, however, that some indigenous cultures such as Māori do not see the individual as discrete from their whanau (family) or iwi (tribe) and that their experiences are more important

than a diagnosis for one of their individuals and their diagnosis. (Staps *et al*. 2019).

Receiving a psychiatric diagnosis can be experienced as standardizing, objectifying, and stigmatizing (Damsgaard *et al*. 2021). For the recovery journey to proceed, people with lived experiences of mental distress need to feel visible as people and have their voices heard. People experiencing mental distress typically experience a loss of self and identity that needs to be worked through for recovery to become possible (Kerr *et al*. 2020). The therapeutic task is for the individual to redefine themselves and reconstruct a new sense of self (Deegan 2002; Slade 2009).

## Psychiatric discourse

There are some very good historical accounts of the emergence of psychiatry and how it institutionalized its power by aligning with medicine [see e.g. the work of Scull (1979, 2021b, 2022)]. One strategy used to bolster its power was to lay claim to knowledge of the distinction between normal and abnormal behaviours by naming any discrepancy as evidence of mental disorder. It has been proposed that psychiatric discourse sets the parameters of normality and abnormality, around social and cultural expectations of productivity, moderation, unitariness, and rationality (Crowe 2000). It defines mental disorder as an absence or deficit of these social norms under the guise of some biological causation. Yet psychiatry has been unable to solve questions of causation, and while biology predisposes some people to heightened vulnerability, this is not disorder-specific (Scull 2021a).

Psychiatric discourse is focused principally on diagnosis, containment, and drug treatment. It bases its claims to legitimacy and privilege on the medical model, and, to do this, mental distress is aligned with medical diseases as evidence of biological deficit. However, despite decades of intensive research, there is no substantive biological evidence that mental disorders are diseases in the medical sense. In the absence of genetic markers that align with diagnoses, psychiatry has undertaken considerable research in the past two decades into identifying peripheral biomarkers (e.g. cortisol responses, vitamin levels, inflammation) that could provide evidence for mental disorders. However, as identified in an evidence-based umbrella review of 162 potential peripheral biomarkers there was very little evidence to support any consistent association (Carvalho *et al*. 2020). The diagnosis and clinical management of major mental disorders are based on psychopathology while treatment remains predominantly based on 'trial and error' (Leucht *et al*. 2012). In medicine, symptoms are subjective evidence of underlying disease or physical disturbance, but in psychiatry, the disease or physical disturbance has not been sufficiently established. The congruence in diagnostic processes between psychiatry and medicine is tenuous at best.

There is very little similarity between the basis of medical diagnoses and psychiatric ones. In medicine, an explanation of the illness employs knowledge derived from empirical natural sciences, which enables the illness to be understood as the result of disturbed anatomy or physiology but there is no such biological evidence available in psychiatry (Moncrieff & Middleton 2015). While there has been scientific progress made in psychiatry, the clinical utility of the findings to date has been very limited and the necessary aetiological understanding of the various categories of mental disorders does not exist. (Scull 2021a).

Despite this, diagnosis is the cornerstone of psychiatric discourse. People in mental distress are given a diagnosis as defined in either the Diagnostic and Statistical Manual-5 (American Psychiatric Association 2013) or the International Classification of Diseases (World Health Organization 2019). The DSM-5 task force initially claimed that all diagnoses in the most recent diagnostic manual would be underpinned by biological markers, unlike previous manuals. However, in the absence of consistent biomarkers, the task force abandoned its attempts to provide evidence to support its ever-expanding diagnoses and stuck to the use of expert consensus. The mental disorders enumerated in the DSM-5 are historically contingent and vulnerable to social and political influences (Kendler 2016). They often reflect the research, insurance, commercial, and financial interests of the task group members. It has been identified that there were financial ties between DSM panel members and pharmaceutical companies (Cosgrove & Vaswani 2019). The ICD-II also used expert consensus in the absence of biological evidence but was perhaps more inclusive in who it sought opinions. Psychiatric diagnosis effectively constructs the individual's past, present, and future and determines treatment and prognosis, while also promoting stigma. By claiming to know and name what is happening to the person experiencing mental distress, psychiatry bolsters its claims of 'expertise'. There is accumulating evidence that these explanations contribute to stigmatizing attitudes (Schroder *et al*. 2020).

Psychiatric diagnoses and treatments are also culturally biased. Diagnoses are based on western assumptions

of what constitutes normal behaviour (Crowe 2000), and many studies of psychiatric treatments do not include indigenous people, and clinical trials generate findings that are not generalizable across ethnicity (Burkhard *et al*. 2021). Drug treatments are the primary, and almost exclusive, therapeutic modality in psychiatry. The basis for prescribing drugs is related to presumptions of biological abnormality that contribute to biological effects that give rise to mental disorders. However, using depression as an example, despite huge amounts of research, a systematic umbrella review of the evidence (Moncrieff *et al*. 2022) reported that there is no convincing evidence of a biochemical basis for depression. In addition to limited efficacy, there is also emerging evidence that selective serotonin reuptake inhibitors and serotonin and norepinephrine reuptake inhibitors are associated with high rates of adverse effects in the personal and interpersonal domains and high rates of withdrawal effects (Timimi *et al*. 2018).

I propose that it is the dominance and authority of psychiatric discourse and the way in which it maintains its power, that prevents meaningful change in mental health services. Given the limited evidence to support its biological legitimacy and government reviews recommending alternative approaches, it is curious that psychiatric discourse continues to maintain its authority and power. Although psychiatric knowledge is weak, psychiatric authority is powerful (Pilgrim 2013). I suggest three strategies are at play in reproducing the dominance and authority of psychiatric discourse. The first is to embed itself in medicine, as discussed above. In addition, to maintain its authority psychiatric discourse lays claim to expertise in identifying and managing social risk and perpetuates its power through an echo chamber that reinforces opinion under the guise of evidence.

Psychiatric discourse claims to be able to identify and manage social risk, that is, the risk to self or others. By asserting this expertise, it has the power to compulsorily detain and treat people who pose a risk. Psychiatrists are brought in as risk consultants by claiming an ability to predict future behaviours (Rose 2018). Under the New Zealand Mental Health Act (Compulsory Treatment and Assessment; NZ Government, 1992), a person can be compulsorily detained and treated if they are assessed as having a mental disorder. In this context, mental disorder means an abnormal state of mind (whether of a continuous or an intermittent nature), characterized by delusions or by disorders of mood or perception or volition or cognition, of such a degree that it (i) poses a serious danger to the health or safety of that person or of others, or (ii) seriously diminishes the capacity of that person to take care of himself or herself. However, there is little evidence to support the specificity and accuracy of risk assessment in predicting harm to self or others. There is an absence of research evidence supporting the ability of violence risk assessment tools to reduce or prevent adverse events despite the widespread reliance on these tools which can provide a false sense of security that risk has been adequately addressed (Wand 2012). Because there are problems associated with predicting the risk of harm to others and there is a tendency of psychiatrists to err on the side of safety, '[t]he dangerousness criterion effectively condones the detention of many mentally ill people who will never become dangerous, so that it might capture the few who will' (Large *et al*. 2008). Suicide risk assessments also have only modest discriminating power (Large & Ryan 2014). Alongside concerns regarding the validity of risk assessment in predicting suicide, there is also a strong argument that such practices implemented by health services to manage risk, such as formal observations, can be countertherapeutic and carry many costs to those with lived experience (Manuel *et al*. 2018). A key determinant in the process of risk assessment is the person's psychiatric diagnosis; however, those with lived experience have suggested that increase in the risk of harm is linked to the clinical culture (Fletcher *et al*. 2021).

From its inception, psychiatry became not merely a scientific enterprise but a social enterprise because of its mandate to control social deviance and social risk. Particular attributes, characteristics, or behaviours are regarded as signs of potential risk, and this calculation of probable risk effectively constructs an individual's past, present, and future in a particular way that poses a social threat (Crowe & Carlyle 2003). The claim that psychiatric discourse can identify and manage social risk is now integral to not only our mental health services but also our justice and insurance systems. This is despite very limited evidence that such risk can be predicted.

The final strategy that reproduces the power of psychiatric discourse I have termed the 'echo chamber', which is perhaps the most effective strategy. The echo chamber refers to self-affirming and self-filtering processes that give voice to like voices and beliefs (Noar 2021). The term 'echo chamber' has emerged from the discussion of how Internet communities become entrenched in sites that give voice to opinions constructed as facts. The term can also be applied to

the processes by which psychiatric discourse maintains its authority: controlling what constitutes clinical guidelines. The influence of pharmaceutical companies on psychiatry is well documented. The combined commercial and professional self-interests result in undue influence over what diagnostic and treatment recommendations are included in treatment guidelines and taint them as untrustworthy (Cosgrove & Vaswani 2019).

Clinical treatment guidelines claim to be developed using a systematic evidence review of published psychiatric papers supplemented with consensus expert opinion (Lam *et al*. 2016; Malhi *et al*. 2021; National Institute for Health and Care Excellence 2018). While medicine has increasingly relied on evidence from systematic reviews for clinical guidelines and diagnosis, psychiatry has relied on 'expert consensus in the absence of evidence (Kendler & Solomon 2016). To explore this further, I analysed recent treatment recommendations for mood disorders from the Australian and New Zealand College of Psychiatry (Malhi *et al*. 2021). The analysis of the recommendations in these guidelines identified that 60% were 'consensus-based evidence', and only 26% of recommendations were supported by Level I or II evidence, that is, well-supported, efficacious treatments, or probably efficacious treatment.

The basis for these claims of expert consensus is, however, poorly described. These guidelines have not described the usual process for medical expert clinical consensus which is developed in working groups using structured and transparent approaches, for example the Delphi technique, nominal group technique, or consensus conferences for developing consensus (Black *et al*. 1999). Clinical guidelines in psychiatry are highly cited, and there is an assumption that recommendations are derived from scientific evidence; however, a closer look suggested it was mostly 'expert' opinion. The guidelines are highly cited as evidence to support further published opinion and research, and the previous guidelines (Malhi *et al*. 2021) garnered 742 citations times (Google Scholar August 2022). These citations can then be used to reinforce published opinions which can then be used to support future guidelines. A circular process of production and reproduction of psychiatric discourse occurs in which opinions are echoed back and forth to create the illusion of expert consensus. An echo chamber is created in which the key features of psychiatric discourse become truths under the guise of science. In the absence of a description of a rigorous and transparent process describing how expert consensus was obtained, it may be assumed that it is the opinion of the authors and perhaps a small review panel. The evidence for the recommendations provided is weak, yet the guidelines continue to assume credibility that perpetuates their role in the echo chamber.

In summary, psychiatric discourse and recovery principles have little in common. An evaluation of how psychiatric discourse is enacted in relation to recovery principles identified that psychiatric discourse provides the direction of assessment and treatment rather than enabling self-direction; is a diagnosis-driven process rather than being individualized and person-centred; marginalizes the voices of those with lived experience rather than empowering those voices; has a focus on biochemical deficits rather than a holistic focus; is tokenistic in including those with lived experience in decision-making; is linear in its focus with assessment, diagnosis, and prescription driving the direction; is medication-reliant rather than strengths-based; positions those with lived experience as passive 'patients'; and fails to instil hope by constructing psychiatric disorder as a biological entity that can lead to ongoing relapses.

## Recovery and/or psychiatric discourse

To understand this divergence between psychiatric discourse and recovery principles, the two were analysed in relation to some key attributes: knowledge base, ontological position, aetiological position, evidence base, focus, nature of the relationship, therapeutic task, and prognosis. The analysis revealed that the core characteristics that underpin recovery principles are the antithesis of psychiatric discourse as I have described in Table 1.

The two approaches to mental health care have nothing in common, and attempting to integrate the two into mental health services without positive action in terms of resources and authority will perpetuate the dominance of psychiatric discourse and position recovery principles as a peripheral value with limited impact on mental health services. Lived experience is as valid of a form of knowledge as psychiatric discourse but it currently lacks the authority. Recovery principles have been made to fit a health infrastructure where their meaning is shaped by a traditional focus on hierarchy, clinical tasks, professional language, medicalization, and psychiatric power (Le Boutillier *et al*. 2014). While the rhetoric is abundant, the reality is that the language of recovery is used to create an illusion. The power

**TABLE 1** *Core characteristics recovery and psychiatry*

| | Recovery | Psychiatry |
|---|---|---|
| Knowledge base | Experiential | Reproduction of medical model |
| Ontological position | Holistic and person-centred | Categorical and reductive |
| Aetiological position | Trauma, social, and cultural stressors | Biological deficit |
| Evidence base | Narratives of experience | Limited biological evidence |
| Focus | Behaviour, thoughts, and feelings | Search for symptoms of underlying deficit |
| Nature of relationship | Active participation | Passive recipient of 'expertise' |
| Therapeutic task | Reconstruction of new sense of self | Diagnosis and medication |
| Prognosis | Hopeful of change | Recurrence and stigma |

embedded in diagnosis and medication based on 'evidence' or 'expertise' continues to thrive. Discrepant priorities across these different levels of the health system lead to a clash of paradigms and competing agendas in supporting recovery, with practice most often dictated by power within the system (Le Boutillier *et al*. 2014). I suggest that the illusion of the current 'recovery focus' embedded in psychiatric discourse within psychiatric services perpetuates stigma, likely undermines recovery, and expediates recurrence of mental distress.

There is a distorted demand for psychiatric care that is based on an ever-expanding notion of what constitutes a psychiatric disorder compounded by an inaccurate gauge of the efficacy of psychiatric treatments, particularly pharmacological ones (Steingard 2019). The lack of availability of psychiatric treatment is a popular topic across many forms of media. Stimulating the demand for psychiatric services has been an effective strategy for shoring up the psychiatric discourse. There is a need to radically broaden what counts as knowledge and whose knowledge counts (Rose & Kalathil 2019).

People who experience mental distress experience injustice when their identities are devalued through the acquisition of psychiatric diagnoses which in turn leads to stigmatization (Harper & Speed 2014). Institutional structures create injustice where there are disparities in resources, opportunities, and representation between majority and non-majority perspectives, for example, inequalities in access to treatment, experiences of health services, and treatment outcomes (Hui *et al*. 2021). It occurs when treatment or services cause harm, even when the professed intentions underpinning the institution are benevolent. It is characterized best through epistemic injustice which occurs when the person seeking treatment is not listened to or taken seriously, is regarded as not understanding their experiences, and is not considered a reliable source of knowledge or information (Drozdzowicz 2021). The 'patient' is side-lined in an epistemic search for diagnosis and medication. It occurs when a person's treatment preferences are dismissed because the psychiatric diagnosis attributed to that person suggests an inability to think rationally or clearly (Kurs & Grinspoon 2018). In the face of this institutional injustice, it has been suggested that at the clinician level approaches are needed to avoid two related dangers: diagnostic overshadowing in which a person's experiences and physical symptoms are misattributed to mental illness and granting master status to one aspect of a person's identity by disregarding other aspects (Hui *et al*. 2021). Given the chasm of differences between recovery principles and psychiatric discourse and the injustices embedded, is it possible to build a bridge between the two?

## RELEVANCE FOR CLINICAL PRACTICE

Recovery principles and psychiatric discourse are fundamentally dissimilar. However, if the authority embedded in psychiatric discourse can be contested and recovery principles are privileged, then it may be possible that psychiatry plays a role where it supports recovery, where it places the needs of those with lived experience over the need to maintain dominance. Mental health nurses have internalized the social positioning imposed on them by the long-standing hegemony of medicine and more recent deference to psychology (Lakeman & Hurley 2021). Although they are often complicit in maintaining psychiatric discourse, they also paradoxically engage with discourses more aligned with recovery principles (Joergensen & Praestegaard 2018). However, they do have a range of less dominant discourses that they engage with. It has been identified that nurses engage with both technical (medical) and caring discourses while remaining largely silent (Canam 2008). Mental health nurses comply with the bureaucratic system of mental health care while using the same system to ensure the needs of those with lived experience are met and as such are in an empowered position to renegotiate the characteristics of mental health services (Hurley *et al*. 2008). The caring discourse is often invisible in the face of psychiatric discourse.

This discourse needs to be more visible to support recovery principles. Several models have been proposed to do this (Barker 2001; Daya *et al*. 2020; Santangelo *et al*. 2018) but barriers to their implementation persist (Harris & Panozzo 2019). In the context of psychiatric discourse, the mental health nursing role is often confined to the provision of custodial care (risk assessment, special observations, and seclusion) in the acute phase and risk management and promotion of medication adherence during the subacute phase (Crowe 2017).

No mental health service (or peer-led service) can genuinely claim to promote recovery principles at the same time as psychiatric discourse dominates. The current issues facing access to mental health services and effective treatment do not mean we need to further expand current models of service delivery; more resources need to be provided to services that incorporate recovery principles. One way to do this is to instigate service audits and key performance indicators that privilege recovery principles. Rather than prioritizing the current key performance indicators (reducing restrictive practice, improving service transitions, improving medication management and prescribing, learning from serious adverse events and consumer experience, and maximizing physical health; Health Quality and Safety Commission New Zealand 2021), recovery principals should be given priority. Services could be audited in terms of individualized and person-centred care in which the individual or their family determines treatment, empowerment and genuine participation in decision-making, treatments determined in consultation with those with lived experience, holistic rather than purely diagnosis-driven, active peer-support at all stages of assessment and treatment process, and respect for the individual's needs rather than the organization's.

Recovery-based services need to be led by those with lived experience with clinicians providing support to facilitate connectedness, hope, optimism, identity, meaning and purpose, and empowerment. Services would no longer be structured around diagnosis but rather the clinician and the person in mental distress and their family would work together to develop formulations based on predisposing, precipitating, perpetuating, and protective factors (Crowe *et al*. 2008). This 4 P model examines the events and patterns in the person's life that contribute to their current distress. It can produce meaningful context-specific formulations, reflecting the person's social and cultural needs instead of decontextualized diagnoses into which both the person and their mental distress are shoe-horned. These formulations would form the basis of treatment.

Treatment might involve the short-term use of medication to manage the behaviours, thoughts, and feelings associated with mental distress. Medication would be prescribed by psychiatrists or nurse practitioners; however, I propose this would be a technical role to support the person in their recovery – a psychiatric technician. Medication cannot treat any assumed underlying cause, but it can bring relief and the opportunity to step back from an overwhelming crisis.

Rather than focusing on risk and containment of mental health, nurses could provide therapeutic interventions based on fostering connectedness, hope, optimism, identity, meaning and purpose, and empowerment. Evidence for the effectiveness of these interventions would not be based on 'symptom reduction' but rather on the experience of those who are recipients.

## CONCLUSION

Psychiatric discourse maintains and reproduces its power through its alignment with medicine, its claims of expertise in identifying and managing social risk, and maintaining its own echo chamber that utilizes publication strategies to enforce its position. There is no congruence between psychiatric discourse and recovery principles in either how it is enacted in practice or its philosophical underpinnings.

The agenda for change is urgent because of the injustices that pervade mental health services dominated by psychiatric discourse. Mental health nurses need to accept this as a challenge to promote models of service delivery and treatment that are not embedded in psychiatric discourse. Institutional transformation is required with the greater authority given to transdisciplinary approaches (Hui *et al*. 2021) that position those with lived experience as central. We need to promote the need to audit recovery principles as key performance indicators, and we need to shift from reinforcing psychiatric discourse to negotiating reforms that privilege lived experience.

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