Important Language Considerations in Developing Person-Centered Plans

Despite the fact that the process behind a recovery plan may be largely recovery-oriented, the translation of this process into the actual language of the planning document itself continues to be a core challenge of all providers who are committed to creating person-centered plans. The following are offered as overarching guidelines that should be considered regarding language that is incorporated in both written documents and verbal interactions.

1. The language used is neither stigmatizing nor objectifying. At all times "person-first" language is used to acknowledge that the disability is not as important as the person's individuality and humanity (e.g., "a person with schizophrenia" versus "a schizophrenic" or a "person with an addiction" versus "an addict"). Employing person-first language does not mean that a person's disability is hidden or seen as irrelevant; however, it also is not be the sole focus of any description about that person. To make it the sole focus is depersonalizing and derogatory, and is no longer considered an acceptable practice.

2. The language used also is empowering, avoiding the eliciting of pity or sympathy, as this can cast people with disabilities in a passive, "victim" role and reinforce negative stereotypes. For example, just as we have learned to refer to "people who use wheelchairs" as opposed to "the wheelchair bound," we should refer to "individuals who use medication as a recovery tool" as opposed to people who are "dependent on medication for clinical stability."

3. Words such as "hope" and "recovery" are used frequently in documentation and delivery of services.

4. Providers attempt to interpret perceived deficits within a strengths and resilience framework, as this will allow the individual to identify less with the limitations of their disorder. For example, an individual who takes their medication irregularly may be automatically perceived as "non-compliant," "lacking insight," or "requiring monitoring to take meds as prescribed." However, this same individual could be seen as "making use of alternative coping strategies such as exercise and relaxation to reduce reliance on medications" or could be praised for "working collaboratively to develop a contingency plan for when medications are to be used on an 'as-needed' basis."

5. Avoid using diagnostic labels as "catch-all" means of describing an individual (e.g., "Is a 22-year-old borderline patient with…"), as such labels often yield minimal information regarding the person's actual experience or manifestation of their illness or addiction. Alternatively, an individual's needs are best captured by an accurate description of their functional strengths and limitations. While diagnostic terms may be required for other purposes (e.g., classifying the individual to support reimbursement from funders), their use should be limited elsewhere in the person-centered planning document.

In addition to the above overarching guidelines regarding the use of language, the following table offers basic language "tips" that have been suggested in the literature as simple ways in which to enhance the recovery orientation of written planning documents.

Interpretation from a Recovery-Oriented Perspective	
Deficit-Based or "Catch-all" Perspective	**Recovery-Oriented, Asset-Based Perspective**
A schizophrenic, a borderline	A person diagnosed with schizophrenia who experiences the following…
An addict/junkie	**A person diagnosed with an addiction who experiences the following…
Clinical case manager	Recovery Coach/Recovery Guide ("I'm not a case, and you're not my manager!")
Front-line staff/In the trenches	Direct care; Support staff providing compassionate care
Substance abuse/abuser	Person with an addiction to substances/Substance use interferes with person's life
Suffering from	Working to recover from; Experiencing; Living with
Treatment Team	Recovery Team; Recovery Support System
LMHA - Local Mental Health Authority	Recovery and Wellness Center
High-functioning vs. Low-functioning	Person's symptoms interfere with their relationship (work habits, etc.) in the following way…
Acting out	Person disagrees with Recovery Team and prefers to use alternative coping strategies
Self-help	Recovery support groups; Mutual aid groups
Denial; Unable to accept illness; Lack of insight	Person disagrees with diagnosis; Does not agree that they have a mental illness; Pre-contemplative stage of recovery
Resistant	Not open to…; Chooses not to…; Has own ideas…
Weaknesses	Barriers to change; Needs
Unmotivated	Person is not interested in what the system has to offer; Interests and motivating incentives unclear
Clinical decompensation, relapse, failure	Person is re-experiencing symptoms of illness/addiction; An opportunity to develop, implement, and/or apply coping skills and to draw meaning from managing an adverse event; Re-occurrence
Maintaining clinical stability/abstinence	Promoting and sustaining recovery
Untreated alcoholics	People not yet in recovery; Precontemplative/comtemplative stage of recovery
Prevent suicide	Promote life
Puts self/recovery at risk	Takes chances to grow and experience new things
Non-compliant with medications/treatment	Prefers alternative coping strategies (e.g., exercise, structured time, time with family) to reduce reliance on medication; Has a crisis plan for when meds should be used; Beginning to think for oneself
Minimize risk	Maximize growth
Consumer (in addictions community)	Person in recovery; Person working on recovery
Patient (in mental health community)	Individual; Consumer; Person receiving services
Treatment works	Person uses treatment to support their recovery
Treatment system	Recovery Community
Discharged to aftercare	Connected to long-term recovery management

Enable	Empower the individual through empathy, emotional authenticity, and encouragement
Frequent Flyer	Gives us many opportunities to intervene and support
Dangerous	Specify behavior
Manipulative	Resourceful; Really trying to get help
Entitled	Aware of one's rights
Dangerous to Others (DTO)/Dangerous to (DTS)/Gravely Disabled (GD)	Describe behaviors that render one danger to self/others, Self etc.
Baseline	What a person looks like when they are doing well
Helpless	Unaware of capabilities
Hopeless	Unaware of opportunities
Grandiose	Has high hopes and expectations of self
User of the system	Resourceful; Good self-advocate

** Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected. For instance, the personal preferences of some individuals with substance use disorders, particularly those who work the 12 Steps as a primary tool of their recovery, may at times be inconsistent with person-first language. Within the 12-Step Fellowship, early steps in the recovery process involve admitting one's powerlessness over a substance and acknowledging how one's life has become unmanageable. It is also common for such individuals to introduce themselves as: "My name is X and I am an alcoholic." This preference is respected as a part of the individual's unique recovery process, and it is understood that it would be contrary to recovery principles to pressure the person to identify as "a person with alcoholism" in the name of person-first language or principles. Use of person-first language is in the service of the person's recovery; it is not a superordinate principle to which the person must conform. While the majority of people with disabilities prefer to be referred to in this manner, when in doubt, ask the individual what they prefer.

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National Institute for Mental Health in England. NIMHE Guiding Statement on Recovery. January, 2005.

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