2nd Edition

Toward a Vision of Recovery

for Mental Health and Psychiatric Rehabilitation Services

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Center for Psychiatric Rehabilitation—Boston University

Published by:

Center for Psychiatric Rehabilitation
Sargent College of Health and Rehabilitation Sciences
Boston University
940 Commonwealth Avenue West
Boston, MA 02215

http://www.bu.edu/cpr/

The Center for Psychiatric Rehabilitation is partially funded by the National Institute on Disability and Rehabilitation Research and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Printed in the United States of America

ISBN–13: 978-1-878512-21-5

ISBN–10: 1-878512-21-8

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About the Author

William A. Anthony, PhD, is executive director of the Center for Psychiatric Rehabilitation at Boston University and has served in that capacity since the Center's inception in 1979. Dr. Anthony, one of the founders of the modern movement in psychiatric rehabilitation and a pioneer in the field of recovery-oriented rehabilitation, has an international reputation as a researcher, author, educator, and advocate in the field of psychiatric rehabilitation. He has received numerous awards including the Outstanding Psychologist Award from the National Alliance for the Mentally Ill, the New York IAPSRS Lifetime Achievement Award, the American Association of Psychosocial Rehabilitation (AAPR) Fordyce Award, and NAMI-NYC Ken Book Award. He has authored over 100 journal articles, 15 textbooks, and numerous book chapters.

About the Center

The Center for Psychiatric Rehabilitation at Boston University is a research, training, and service organization dedicated to improving the lives of people who have psychiatric disabilities.

The Center's work is guided by the most basic of rehabilitation values—that first and foremost, persons with psychiatric disabilities have the same goals and dreams as any other person. They want a decent place to live, suitable work, social activities, and friends to whom to turn in times of crisis. The mission of the Center is to increase knowledge in the field of psychiatric rehabilitation and to apply this body of knowledge to train treatment personnel, to develop effective rehabilitation programs, and to assist in organizing both personnel and programs into efficient and coordinated service delivery systems.

The Center has been jointly funded since 1979 as a Research and Training Center in mental health by the National Institute on Disability and Rehabilitation Research (NIDRR) and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA).

Preface

Recovery—a concept that has emerged from the consumer/survivor literature—is a vision that can revolutionize how we think about people with severe mental illnesses. While consumer/survivors have been experiencing recovery, and to a lesser extent, writing and speaking about recovery, professionals are just now trying to understand the meaning and implications of a vision of recovery. These readings are designed to inform people about the need for a recovery vision, to increase people's understanding of the recovery vision, and to stimulate an analysis of the implications of a recovery vision for both mental health practitioners and system planners.

The readings on recovery are presented chronologically, from 1992 to the present. They reflect my thoughts on recovery beginning with a declaration in 1992 that recovery should be the guiding vision of the entire mental health field. The writings conclude with an analysis of recovery as the common vision of the fields of mental health and addictions.

Individuals can use these materials for self-study about recovery; or inservice or preservice instructors and trainers can use them to initiate group discussions about the implications of a recovery vision for service providers, researchers, administrators, families, and most importantly, consumer/survivors.

The next several decades will see the recovery vision emerge as a vision commensurate with the vision of prevention and cure of mental illnesses. Recovery from psychiatric disabilities is a vision that will pull us, prod us, and direct us in the 21ST century. Hopefully, these writings will inform and stimulate your thinking about recovery from psychiatric illnesses and the implications of the recovery vision.

WILLIAM A. ANTHONY

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A Revolution in Vision

William A. Anthony

There is a revolution brewing in the field of severe mental illness. No—I'm not referring to the revolution in medical treatment brought about by future medical discoveries. I'm referring to a revolution that is beginning to occur right now. It is a revolution in vision—in what is believed to be possible for people with severe mental illness.

For the past century it was believed that people with severe mental illness must suffer a lengthy duration of severe disability, with a deteriorating course over their lifetime. As recently as this last decade the diagnostic manual of the American Psychiatric Association characterized schizophrenia in this way "the most common outcome is one of acute exacerbations with increasing residual impairments between episodes." (American Medical Association, 1980, p. 195) In the decade of the 1990s the question is now being raised repeatedly by consumers and their families as to how much of the long-term disabling effects of mental illness are due to the disease itself or to the uninformed way we view severe mental illness. I sense a revolution in thinking. Personally, after 25 years of practice, research, and listening to consumers and their families, I am more convinced than ever that recovery from severe mental illness is possible for many more people than was previously believed. I believe that much of the chronicity in severe mental illness is due to the way the mental health system and society treat mental illness and not the nature of the illness itself.

Recovery from mental illness is not the same as cure. It means regaining control over one's life if not one's illness. It means leading a useful, satisfying life even though symptoms may reoccur.

A vision of the possibilities of recovery can change how we treat people with mental illness even if the illness itself hasn't changed. Consider how the vision for people with mental retardation has changed. Not so long ago people with Down's Syndrome were expected to live their lives in institutions. Now this is the exception rather than the norm. Has the nature of the disorder changed? No—what has changed is the vision of what is possible, and as a result of this change in vision the mental retardation system and society changed. It was a revolution in vision. Sure, there have been changes in where we place (dump?) people with severe mental illness, but no major, sig-

nificant change in how they are viewed. The last major revolution in vision was led by Philippe Pinel, almost 200 years ago, when he helped to unchain people with mental illness. Here is an account of a conversation Pinel had at that time:

> Pinel immediately led him to the section for the deranged, where the sight of the cells made a painful impression on him. He asked to interrogate all the patients. From most, he received only insults and obscene apostrophes. It was useless to prolong the interview. Turning to Pinel: "Now citizen, are you mad yourself to seek to unchain such beasts?" Pinel replied calmly: "Citizen, I am convinced that these madmen are so intractable only because they have been deprived of air and liberty." (Foucault, 1973, p. 242)

The resulting change in how people with mental illness were treated at that time occurred not because of a scientific break-through but because of Pinel's breakthrough in vision. Pinel envisioned a more humane type of treatment. Two hundred years later we must take the chains off our vision so that a vision of recovery becomes possible. A recovery vision has been stifled by a lack of innovative treatment and rehabilitation options, and by a mental health culture which fails to recognize and rejoice in the person's potential behind the illness.

It appears that it will be up to consumers and their family members to lead this revolution in vision—to guide or drag we professionals toward the 21ST century. Vision, as well as science, must be nurtured if each of us is going to become all we can be. A recovery vision can be as revolutionary and as necessary as a PET scan. One need not be a research scientist to play a role in making the recovery vision a reality. We may all participate in the recovery revolution.

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The Decade of Recovery

William A. Anthony

Reprinted with permission from: Anthony, W. A. (1993). Editorial. *Psychosocial Rehabilitation Journal, 16* (4), 1.

As most of us already know, the 1990s has been declared the "Decade of the Brain." Researchers are working toward the key objective of the "Decade of the Brain" resolution so that research will provide better treatments and, eventually, cures for mental illness.

I would like to suggest that the decade of the 1990s also be known as the "Decade of Recovery." I believe that by more widespread use of our existing techniques and settings, grounded as they are in our current community support and rehabilitation philosophy, many more people with psychiatric disabilities can recover than currently do. Recovery from mental illness is a vision commensurate with the researcher's vision of mental illness prevention and cure. Recovery from mental illness is a vision for services researchers, providers, consumer/survivors, and their families. It is a vision that has emerged out of the consumer literature.

The recovery vision transcends the arguments about whether severe mental illness is caused by physical and/or psychosocial factors. People with severe physical disabilities, such as spinal cord injury, can recover even though the spinal cord has not.

Likewise, people with severe psychiatric disabilities can recover even though they still may experience symptom exacerbations.

Recovery, as we currently understand it, means growing beyond the catastrophe of mental illness and developing new meaning and purpose in one's life. It means taking charge of one's life even if one cannot take complete charge of one's symptoms. Much of the chronicity that is thought to be a part of people's mental illness may be due to the way the mental health system and society treat people with severe mental illness. Contributing to people's chronicity are factors such as stigma, lowered social status, restrictions on choice and self-determination, the lack or partial lack of rehabilitation opportunities, and low staff expectations. Drastic system changes are needed if we wish to support people's recovery, rather than hinder people's recovery.

I, for one, have seen too many recovery "miracles" not to believe that significant recovery is possible for many more people with psychiatric disabilities. Recovery, like prevention and cure, must take its rightful place as our vision in this decade, the "Decade of Recovery."

Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s

William A. Anthony

Reprinted with permission from: Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16* (4), 11–23.

Abstract: The implementation of deinstitutionalization in the 1960s and 1970s, and the increasing ascendance of the community support system concept and the practice of psychiatric rehabilitation in the 1980s, have laid the foundation for a new 1990s vision of service delivery for people who have mental illness. Recovery from mental illness is the vision that will guide the mental health system in this decade. This article outlines the fundamental services and assumptions of a recovery-oriented mental health system. As the recovery concept becomes better understood, it could have major implications for how future mental health systems are designed.

The seeds of the recovery vision were sown in the aftermath of the era of deinstitutionalization. The failures in the implementation of the policy of deinstitutionalization confronted us with the fact that a person with severe mental illness wants and needs more than just symptom relief. People with severe mental illnesses may have multiple residential, vocational, educational, and social needs and wants. Deinstitutionalization radically changed how the service system attempts to meet these wants and needs. No longer does the state hospital attempt to meet these multiple wants and needs; a great number of alternative community-based settings and alternative inpatient settings have sprung up since deinstitutionalization. This diversity has required new conceptualizations both of how services for people with severe mental illnesses should be organized and delivered, and of the wants and needs of people with severe mental illness. This new way of thinking about services and about the people served has laid the foundation for the gradual emergence of the recovery vision in the 1990s.

As a prelude to a discussion of the recovery vision, the present paper briefly describes the community support system (CSS) concept and the basic services integral to a comprehensive community support system. Next, the more thorough understanding of the total impact of severe mental illness, as conceptualized in the rehabilitation model, is succinctly overviewed. With the CSS service configuration and the rehabilitation model providing the historical and conceptual base, the recovery concept, as we currently understand it, is then presented.

The Community Support System

In the mid-1970s, a series of meetings at the National Institute of Mental Health (NIMH) gave birth to the idea of a community support system (CSS), a concept of how services should be provided to help persons with long-term psychiatric disabilities (Turner & TenHoor, 1978). Recognizing that post-deinstitutionalization services were unacceptable, the CSS described the array of services that the mental health system needed for persons with severe psychiatric disabilities (Stroul, 1989). The CSS filled the conceptual vacuum resulting from the aftermath of deinstitutionalization (Test, 1984). The CSS was defined (Turner & Schifren, 1979, p. 2) as "a network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community." The CSS concept identifies the essential components needed by a community to provide adequate services and support to persons who are psychiatrically disabled.

The essential components of a CSS have been demonstrated and evaluated since its inception. Test (1984) concluded from her review that programs providing more CSS functions seem to be more effective (with fewer rehospitalizations and improved social adjustment in some cases) than programs that provide fewer CSS functions. More recently, Anthony and Blanch (1989) reviewed data relevant to CSS and concluded that research in the 1980s documented the need for the array of services and supports originally posited by the CSS concept. It appears that the need for the component services of CSS has a base in empiricism as well as in logic. Most comprehensive mental health system initiatives in the 1980s can be traced to the CSS conceptualization (National Institute of Mental Health, 1987).

Based on the CSS framework, the Center for Psychiatric Rehabilitation has refined and defined the services fundamental to meeting the wants and needs of persons with long-term mental illness. Table 1 presents these essential client services.

Table 1. Essential Client Services in a Caring System

Service Category	Description	Consumer Outcome
Treatment	Alleviating symptoms and distress	Symptom relief
Crisis intervention	Controlling and resolving critical or dangerous problems	Personal safety assured
Case management	Obtaining the services client needs and wants	Services accessed
Rehabilitation	Developing clients' skills and supports related to clients' goals	Role functioning
Enrichment	Engaging clients in fulfilling and satisfying activities	Self-development
Rights protection	Advocating to uphold one's rights	Equal opportunity
Basic support	Providing the people, places, and things client needs to survive (e.g., shelter, meals, health care)	Personal survival assured
Self-help	Exercising a voice and a choice in one's life	Empowerment

Adapted from: Cohen, M., Cohen, B., Nemec, P., Farkas, M. & Forbess, R. (1988). *Training technology: Case management.* Boston: Boston University Center for Psychiatric Rehabilitation.

The Impact of Severe Mental Illness

This new understanding of the importance of a comprehensive, community-based service system is based on a more thorough and clear understanding of that system's clients. The field of psychiatric rehabilitation, with its emphasis on treating the consequences of the illness rather than just the illness per se, has helped bring to this new service system configuration a more complete understanding of the total impact of severe mental illness. The psychiatric rehabilitation field relied on the World Health Organization's 1980 classification of the consequences of disease to provide the conceptual framework for describing the impact of severe mental illness (Frey, 1984).

In the 1980s, proponents of psychiatric rehabilitation emphasized that mental illness not only causes mental impairments or symptoms but also causes the person significant functional limitations, disabilities, and handicaps (Anthony, 1982; Anthony & Liberman, 1986; Anthony, Cohen, & Farkas, 1990; Cohen & Anthony, 1984). The World Health Organization (Wood,

Table 2. The Psychiatric Rehabilitation Model: The Negative Impact of a Severe Mental Illness

Stages ▸	**I. Impairment**	**II. Dysfunction**	**III. Disability**	**IV. Disadvantage**
Definitions ▸	Any loss or abnormality of psychological, physiological, or anatomical structure or function	Any restriction or lack of ability to perform an activity or task in the manner or within the range considered normal for a human being	Any restriction or lack of ability to perform a role in the manner or within the range considered normal for a human being	A lack of opportunity for an individual that limits or prevents the performance of an activity or the fulfillment of a role that is normal (depending on age, sex, social, cultural factors) for that individual
Examples ▸	Hallucinations, delusions, depression	Lack of work adjustment skills, social skills, ADL skills	Unemployment, homelessness	Discrimination and poverty

Adapted from Anthony, W. A., Cohen, M. R. & Farkas, M. D. (1990). *Psychiatric rehabilitation.* Boston: Boston University Center for Psychiatric Rehabilitation.

1980), unlike mental health policymakers, had already developed a model of illness that incorporated not only the illness or impairment but also the consequences of the illness (disability and handicap). As depicted in Table 2, these terms can be reconfigured as impairment, dysfunction, disability, and disadvantage. This conceptualization of the impact of severe mental illness has come to be known as the rehabilitation model (Anthony, Cohen, & Farkas, 1990).

The development of the concept of a comprehensive community support system, combined with the rehabilitation model's more comprehensive understanding of the impact of severe mental illness, has laid the conceptual groundwork for a new vision for the mental health service system of the 1990s. Based on the insights of the 1970s and 1980s, service delivery programs and systems will be guided by a vision of promoting recovery from mental illness (Anthony, 1991).

Recovery: The Concept

The concept of recovery, while quite common in the field of physical illness and disability (Wright, 1983), has heretofore received little attention in both practice and research with people who have a severe and persistent mental illness (Spaniol, 1991). The concept of recovery from physical illness and disability does not mean that the suffering has disappeared, all the symptoms removed, and/or the functioning completely restored (Harrison, 1984). For example, a person with paraplegia can recover even though the spinal cord has not. Similarly, a person with mental illness can recover even though the illness is not "cured."

In the mental health field, the emerging concept of recovery has been introduced and is most often discussed in the writings of consumers/survivors/clients (Anonymous, 1989; Deegan, 1988; Houghton, 1982; Leete, 1989; McDermott, 1990; Unzicker, 1989). Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Recovery from mental illness involves much more than recovery from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-

determination; from the negative side effects of unemployment; and from crushed dreams. Recovery is often a complex, time-consuming process.

Recovery is what people with disabilities do. Treatment, case management, and rehabilitation are what helpers do to facilitate recovery (Anthony, 1991). Interestingly, the recovery experience is not an experience that is foreign to services personnel. Recovery transcends illness and the disability field itself. Recovery is a truly unifying human experience. Because all people (helpers included) experience the catastrophes of life (death of a loved one, divorce, the threat of severe physical illness, and disability), the challenge of recovery must be faced. Successful recovery from a catastrophe does not change the fact that the experience has occurred, that the effects are still present, and that one's life has changed forever. Successful recovery does mean that the person has changed, and that the meaning of these facts to the person has therefore changed. They are no longer the primary focus of one's life. The person moves on to other interests and activities.

Recovery: The Outcome

Recovery may seem like an illusory concept. We still know very little about what this process is like for people with severe mental illness. Yet many recent intervention studies have in fact measured elements of recovery, even though the recovery process went unmentioned. Recovery is a multi-dimensional concept: there is no single measure of recovery, but many different measures that estimate various aspects of it. The recovery vision expands our concept of service outcome to include such dimensions as self-esteem, adjustment to disability, empowerment, and self-determination. However, it is the concept of recovery, and not the many ways to measure it, that ties the various components of the field into a single vision. For service providers, recovery from mental illness is a vision commensurate with researchers' vision of curing and preventing mental illness. Recovery is a simple yet powerful vision (Anthony, 1991).

A Recovery-Oriented Mental Health System

A mental health services system that is guided by the recovery vision incorporates the critical services of a community support system organized around the rehabilitation model's description of the impact of severe mental illness—all under the umbrella of the recovery vision. In a recovery-oriented mental health system, each essential service is analyzed with respect to its capacity to ameliorate people's impairment, dysfunction, disability, and disadvantage (see Table 3).

Table 3. Focus of Mental Health Services

Recovery: Development of new meaning and purpose as one grows beyond the catastrophic effects of mental illness.

Mental Health Services (and Outcomes)	**Impact of Severe Mental Illness**			
	Impairment (Disorder in Thought, Feelings, and Behavior)	**Dysfunction** (Task Performance Limited)	**Disability** (Role Performance Limited)	**Disadvantage** (Opportunity Restrictions)
Treatment (Symptom Relief)	✓			
Crises Intervention (Safety)	✓			
Case Management (Access)	✓	✓	✓	✓
Rehabilitation (Role Functioning)		✓	✓	✓
Enrichment (Self-Development)		✓	✓	✓
Rights Protection (Equal Opportunity)				✓
Basic Support (Survival)				✓
Self-Help (Empowerment)			✓	✓

Table 3 provides an overview of the major consumer outcome focus of the essential community support system of services. The services mainly directed at the impairment are the traditional "clinical" services, which in a recovery-oriented system deal with only a part of the impact of severe mental illness (i.e., the symptoms). Major recovery may occur without complete symptom relief. That is, a person may still experience major episodes of symptom exacerbation, yet have significantly restored task and role performance and/or removed significant opportunity barriers. From a recovery perspective, those successful outcomes may have led to the growth of new meaning and purpose in the person's life.

Recovery-oriented system planners see the mental health system as greater than the sum of its parts. There is the possibility that efforts to affect the impact of severe mental illness positively can do more than leave the person less impaired, less dysfunctional, less disabled, and less disadvantaged. These interventions can leave a person not only with "less," but with "more" —more meaning, more purpose, more success, and more satisfaction with one's life. The possibility exists that the outcomes can be more than the specific service outcomes of, for example, symptom management and relief, role functioning, services accessed, entitlements assured, etc. While these outcomes are the raison d'être of each service, each may also contribute in unknown ways to recovery from mental illness. A provider of specific services recognizes, for example, that symptoms are alleviated not only to reduce discomfort, but also because symptoms may inhibit recovery; that crises are controlled not only to assure personal safety, but also because crises may destroy opportunities for recovery; that rights protection not only assures legal entitlements, but also that entitlements can support recovery. As mentioned previously, recovery outcomes include more subjective outcomes such as self-esteem, empowerment, and self-determination.

Basic Assumptions of a Recovery-Focused Mental Health System

The process of recovery has not been researched. The vagaries of recovery make it a mysterious process, a mostly subjective process begging to be attended to and understood. People with severe disabilities (including psychiatric disabilities) have helped us glimpse the process through their words and actions (Weisburd, 1992). In addition, all of us have directly experienced the recovery process in reaction to life's catastrophes. Based on information gained from the above, a series of assumptions about recovery can be identified.

1. Recovery can occur without professional intervention. Professionals do not hold the key to recovery; consumers do. The task of professionals is

to facilitate recovery; the task of consumers is to recover. Recovery may be facilitated by the consumer's natural support system. After all, if recovery is a common human condition experienced by us all, then people who are in touch with their own recovery can help others through the process. Self-help groups, families, and friends are the best examples of this phenomenon.

It is important for mental health providers to recognize that what promotes recovery is not simply the array of mental health services. Also essential to recovery are non-mental health activities and organizations, e.g., sports, clubs, adult education, and churches. There are many paths to recovery, including choosing not to be involved in the mental health system.

2. A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery. Seemingly universal in the recovery concept is the notion that critical to one's recovery is a person or persons in whom one can trust to "be there" in times of need. People who are recovering talk about the people who believed in them when they did not even believe in themselves, who encouraged their recovery but did not force it, who tried to listen and understand when nothing seemed to be making sense. Recovery is a deeply human experience, facilitated by the deeply human responses of others. Recovery can be facilitated by any one person. Recovery can be everybody's business.

3. A recovery vision is not a function of one's theory about the causes of mental illness. Whether the causes of mental illness are viewed as biological and/or psychosocial generates considerable controversy among professionals, advocates, and consumers. Adopting a recovery vision does not commit one to either position on this debate, nor on the use or nonuse of medical interventions. Recovery may occur whether one views the illness as biological or not. People with adverse physical abnormalities (e.g., blindness, quadriplegia) can recover even though the physical nature of the illness is unchanged or even worsens.

4. Recovery can occur even though symptoms reoccur. The episodic nature of severe mental illness does not prevent recovery. People with other illnesses that might be episodic (e.g., rheumatoid arthritis, multiple sclerosis) can still recover. Individuals who experience intense psychiatric symptoms episodically can also recover.

5. Recovery changes the frequency and duration of symptoms. People who are recovering and experience symptom exacerbation may have a level

of symptom intensity as bad as or even worse than previously experienced. As one recovers, the symptom frequency and duration appear to have been changed for the better. That is, symptoms interfere with functioning less often and for briefer periods of time. More of one's life is lived symptom-free. Symptom recurrence becomes less of a threat to one's recovery, and return to previous function occurs more quickly after exacerbation.

6. Recovery does not feel like a linear process. Recovery involves growth and setbacks, periods of rapid change and little change. While the overall trend may be upward, the moment-to-moment experience does not feel so "directionful." Intense feelings may overwhelm one unexpectedly. Periods of insight or growth happen unexpectedly. The recovery process feels anything but systematic and planned.

7. Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself. Issues of dysfunction, disability, and disadvantage are often more difficult than impairment issues. An inability to perform valued tasks and roles, and the resultant loss of self-esteem, are significant barriers to recovery. The barriers brought about by being placed in the category of "mentally ill" can be overwhelming. These disadvantages include loss of rights and equal opportunities, and discrimination in employment and housing, as well as barriers created by the system's attempts at helping—e.g., lack of opportunities for self-determination, disempowering treatment practices. These disabilities and disadvantages can combine to limit a person's recovery even though one has become predominantly asymptomatic.

8. Recovery from mental illness does not mean that one was not "really mentally ill." At times people who have successfully recovered from severe mental illness have been discounted as not "really" mentally ill. Their successful recovery is not seen as a model, as a beacon of hope for those beginning the recovery process, but rather as an aberration, or worse yet as a fraud. It is as if we said that someone who has quadriplegia but recovered did not "really" have a damaged spinal cord! People who have or are recovering from mental illness are sources of knowledge about the recovery process and how people can be helpful to those who are recovering.

Implications for the Design of Mental Health Systems

Recovery as a concept is by no means fully understood. Much research, both qualitative and quantitative, still needs to be done. Paramount to the

recovery concept are the attempts to understand the experience of recovery from mental illness from those who are experiencing it themselves. Qualitative research would seem particularly important in this regard.

However, it is not too early for system planners to begin to incorporate what we currently think we know about recovery. For example, most first-person accounts of recovery from catastrophe (including mental illness) recount the critical nature of personal support (recovery assumption #2). The questions of system planners are: Should personal support be provided by the mental health system? And if so, how can this personal support be provided? Should intensive case managers fill this role? What about self-help organizations? Should they be expanded and asked to perform even more of this function?

If personal support is characterized as support that is trusting and empathic, do human resource development staff members need to train helpers in the interpersonal skills necessary to facilitate this personal relationship? Quality assurance personnel would need to understand the time it takes to develop such a relationship and figure out ways to assess and document this process.

Recovery, as we currently understand it, involves the development of new meaning and purposes in one's life as one grows beyond the catastrophic effects of mental illness. Does the mental health system help in the search for this new meaning? Does it actively seek to provide opportunities that might trigger the development of new life purposes? Is this the type of service professionals and survivors talk about when the value of "supportive psychotherapy" is mentioned? Is there the support of therapists trained to help persons with mental illness control their lives once again—even without fully controlling their mental illness?

There are a number of possible stimulants to recovery. These may include other consumers who are recovering effectively. Books, films, and groups may cause serendipitous insights to occur about possible life options. Visiting new places and talking to various people are other ways in which the recovery process might be triggered. Critical to recovery is regaining the belief that there are options from which one can choose—a belief perhaps even more important to recovery than the particular option one initially chooses.

Recovery-oriented mental health systems must structure their settings so that recovery "triggers" are present. Boring day treatment programs and inactive inpatient programs are characterized by a dearth of recovery stimulants. The mental health system must help sow and nurture the seeds of recovery through creative programming. There is an important caveat to this

notion of recovery triggers. At times the information provided through people, places, things, and activities can be overwhelming. Different amounts of information are useful at different times in one's recovery. At times denial is needed when a recovering person perceives the information as too overwhelming. At particular points in one's recovery, denial of information prevents the person from becoming overwhelmed. Information can be perceived as a bomb or a blanket—harsh and hostile or warm and welcome. Helpers in the mental health system must allow for this variation in the time frame of information they are providing—and not routinely and simply characterize denial as non-functional.

Similarly, the range of emotions one experiences as one recovers cannot simply be diagnosed as abnormal or pathological. All recovering people, whether mentally ill or not, experience strong emotions and a wide range of emotions. Such emotions include depression, guilt, isolation, suspiciousness, and anger. For many persons who are recovering from catastrophes other than mental illness, these intense emotions are seen as a normal part of the recovery process. For persons recovering from mental illness, these emotions are too quickly and routinely considered a part of the illness rather than a part of the recovery. The mental health system must allow these emotions to be experienced in a nonstigmatizing and understanding environment. Helpers must have a better understanding of the recovery concept in order for this recovery-facilitating environment to occur.

Concluding Comments

Many new questions and new issues are stimulated for system planners by a recovery-oriented perspective. While we are nowhere near understanding the recovery concept nor routinely able to help people achieve it, a recovery vision for the 1990s is extremely valuable.

A vision pulls the field of services into the future. A vision is not reflective of what we are currently achieving, but of what we hope for and dream of achieving. Visionary thinking does not raise unrealistic expectations. A vision begets not false promises but a passion for what we are doing (Anthony, Cohen, & Farkas, 1990).

Previous "visions" that guided the mental health system were not consumer-based. They did not describe how the consumer would ultimately benefit. For example, the deinstitutionalization "vision" described how buildings would function and not how service recipients would function. Similarly, the CSS "vision" described how the service system would function and not the functioning of the service recipients. In contrast, a recovery vision speaks to

how the recipients of services would function. Changes in buildings and services are seen in the context of how they might benefit the recovery vision.

In contrast to the field of services, biomedical and neuroscience researchers have a vision. They speak regularly of curing and preventing severe mental illness. They have helped to declare the 1990s "the decade of the brain." Recovery from mental illness is a similarly potent vision. It speaks to the heretofore unmentioned and perhaps heretical belief that any person with severe mental illness can grow beyond the limits imposed by his or her illness. Recovery is a concept that can open our eyes to new possibilities for those we serve and how we can go about serving them. The 1990s might also turn out to be the "decade of recovery."

The author acknowledges contributions from the personnel of the Center for Psychiatric Rehabilitation in the development of this paper.

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A Recovery-Oriented Service System: Setting Some System Level Standards

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Reprinted with permission from: Anthony, W. A. (2000). A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal, 24*(2), 159–168.

Abstract: In the 1990s a number of state mental health systems, behavioral managed care entities, and county systems of care declared that their service delivery systems were based on the vision of recovery. A recovery vision of service is grounded in the idea that people can recover from mental illness, and that the service delivery system must be constructed based on this knowledge. In the past, mental health systems were based on the belief that people with severe mental illness did not recover, and that the course of their illness was essentially a deteriorative course, or at best a maintenance course. As systems strive to create new initiatives consistent with this new vision of recovery, new system standards are needed to guide the development of recovery oriented mental health systems. Based on research on previous system initiatives and current consensus around accepted recovery practices and principles, a set of system standards that are recovery focused are suggested to guide future system developments.

The 1990s has been called the "decade of recovery" (Anthony, 1991). Two seminal events of the preceding decade paved the way for the concept of recovery from mental illness to take hold in the 1990s. One factor was the writing of consumers (e.g., Anonymous, 1989; Deegan, 1988; Houghton, 1982; Leete, 1989; McDermott, 1990; Unzicker, 1989). For the preceding decades, and culminating in the decade of the 1980s, consumers had been writing about their own and their colleagues' recovery. The consumer literature suggests that recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability (Anthony, 1993). Conceptual and empirical studies on the recovery process have begun to appear (Spaniol, Gagne, & Koehler, 1999; in press). Based on the writings of consumers, Table 1 identifies several assumptions about the recovery process that can be used to guide service system development.

In addition to the conceptual work of consumers, the other major factor precipitating the acceptance of the recovery vision was the empirical work of Harding and her associates, whose research and analytic work initially impacted the field in the 1980s. Over the years Harding (1994) and her colleagues have reviewed a number of long-term research studies, including

Table 1. Assumptions About Recovery

Factors / Items	Reasons
1. Recovery can occur without professional intervention.	Professionals do not hold the key to recovery; consumers do. The task of professionals is to facilitate recovery; the task of consumers is to recover. Recovery may be facilitated by the consumer's natural support system.
2. A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.	Seemingly universal in the recovery concept is the notion that critical to one's recovery is a person or persons in whom one can trust to "be there" in times of need.
3. A recovery vision is not a function of one's theory about the causes of mental illness.	Recovery may occur whether one views the illness as biological or not. The key element is understanding that there is hope for the future, rather than understanding the cause in the past.
4. Recovery can occur even though symptoms reoccur.	The episodic nature of severe mental illness does not prevent recovery. As one recovers, symptoms interfere with functioning less often and for briefer periods of time. More of one's life is lived symptom-free.
5. Recovery is a unique process.	There is no one path to recovery, nor one outcome. It is a highly personal process.
6. Recovery demands that a person has choices.	The notion that one has options from which to choose is often more important than the particular option one initially selects.
7. Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself.	These consequences include discrimination, poverty, segregation, stigma, and iatrogenic effects of treatment.

Adapted from Anthony (1993).

their own (Harding, Brooks, Ashekaga, Strauss, & Breier, 1987a; 1987b), that suggested that a deteriorating course for severe mental illness is not the norm. "The possible causes of chronicity may be viewed as having less to do with the disorder and more to do with a myriad of environmental and other social factors interacting with the person and the illness" (Harding, Zubin, & Strauss, 1987, p. 483). It was the ongoing analysis of long term outcome studies by Harding and associates that provided the empirical basis for the recovery vision.

In contrast to Harding's research and the emerging consumer literature, throughout most of the 1980s, and officially until the appearance of *DSM III-R,* the belief was that severe mental illness, particularly schizophrenia, was a deteriorative disease (American Psychiatric Association, 1980). This seemingly definitive diagnostic conclusion turned out to be ill-conceived, and inhibited acceptance of the recovery vision. Antithetical to the concept of gradual deterioration due to mental illness over time is the concept of recovering over time from mental illness. Harding's later work (Desisto, Harding, McCormick, Ashikaga, & Brooks, 1995a, 1995b) involved a comparison of the long term outcome of people with psychiatric disabilities in two different states. This masterfully designed, three decade long follow-up examined what might account for system wide differences in consumers' recovery, and once again confirmed, as consumers had been saying, that recovery from mental illness was happening.

System Planning and the Recovery Vision

During the 1990s increasing numbers of states and counties adopted a recovery vision as the overriding vision for their system planning. The Community Support System (CSS) perspective as to the critical services needed to be helpful to people with psychiatric disabilities became a part of the thinking of many system planners and administrators. Most comprehensive mental health system initiatives in the 1980s and 1990s can be traced to the CSS conceptualization of basic services (National Institute of Mental Health, 1987). Anthony (1993) used the CSS model as a basis for describing the essential services of a recovery oriented system. Based on the CSS framework, the Center for Psychiatric Rehabilitation has identified the quintessential outcome of each service intervention and the description of the process each service uses to achieve that outcome (Anthony, Cohen, Farkas, & Gagne, 2002). (See Table 2.)

The Boston University Center for Psychiatric Rehabilitation, along with its organizational consultation affiliate, BCPR, is directly aware of recovery

initiatives in selected states in which they have been consulting, including such states as California, Iowa, New York, Ohio, and Washington. The Center is currently collaborating with the National Association of State Mental Health Directors (NASMHPD), the National Association of Consumer/ Survivor Mental Health Administrators (NAC/SMHA) and the Consumer Organization Networking and Technical Assistance Center (CONTAC) to describe and evaluate the extent to which state mental health systems have implemented policies and practices that promote recovery.

Table 2. Essential Services in a Recovery-Oriented System

Service Category	Description	Consumer Outcome
Treatment	Alleviating symptoms and distress	Symptom relief
Crisis intervention	Controlling and resolving critical or dangerous problems	Personal safety assured
Case management	Obtaining the services client needs and wants	Services accessed
Rehabilitation	Developing clients' skills and supports related to clients' goals	Role functioning
Enrichment	Engaging clients in fulfilling and satisfying activities	Self-development
Rights protection	Advocating to uphold one's rights	Equal opportunity
Basic support	Providing the people, places, and things client needs to survive (e.g., shelter, meals, health care)	Personal survival assured
Self-help	Exercising a voice and a choice in one's life	Empowerment
Wellness/prevention	Promoting healthy lifestyles	Health status improved

In Anthony, Cohen, Farkas & Gagne (2002). Adapted from: Cohen, M., Cohen, B., Nemec, P., Farkas, M. & Forbess, R. (1988). *Training technology: Case management.* Boston: Boston University Center for Psychiatric Rehabilitation.

Jacobson & Curtis (2000) have already examined several states' recovery based planning, focusing on how states are using specific strategies to work toward a recovery vision. These strategies include: developing recovery vision statements; educating personnel about recovery; increasing the involvement of consumers and family in planning and service delivery; and implementing "user-controlled" services.

Relevant Systems Level Research

Perhaps the most straightforward definition of a system—and a definition most relevant to today's mental health service system in particular—is that a service system is a combination of services organized to meet the needs of a particular population (Sauber, 1983). A difficulty in creating a mental health service system stems from the varied, multiple needs of the client population. Since deinstitutionalization, many different service systems have been designated as responsible for meeting one or more of the individual needs of persons with long-term psychiatric disabilities (e.g., mental health, health, substance abuse, vocational rehabilitation, social security). The diverse needs of persons with severe psychiatric disabilities for housing, health care, economic, educational, vocational, and social supports dictates coordination between multiple service providers. The mental health service system has become the primary system responsible for preventing individuals who need services from being ignored or falling through the cracks. The challenge to the mental health field has been to develop a mental health service system that could consistently meet the diverse needs of all clients (Reinke & Greenley, 1986). In essence, not only must effective and relevant services be available, but they must also be well-coordinated so that they are easily accessible and efficient, without controlling the consumer to the point of simply replicating the state mental hospital in the community. No doubt the most pressing, obvious national example of service system fragmentation is the system of services for people who have been labeled dually diagnosed, i.e., people with psychiatric disabilities and substance abuse problems (Drake, McLaughlin, Pepper, & Minkoff, 1991; Ridgely, Goldman, & Willenbring, 1990; Ridgely & Dixon, 1995).

Although many studies have noted that multiple, fragmented service systems can interfere with effective service delivery to persons with psychiatric disabilities, until the 1980s little systems-level research was undertaken (Anthony & Blanch, 1989). In 1977, Armstrong reported that 135 federal programs in 11 major departments and agencies had direct impact on people with mental illness. He reported that many of the failures of deinstitutionalization could be attributed to funding disincentives and lack of coordination

among these programs (Armstrong, 1977). Other early evidence of the need for system development and integration included the interrelationship of health and mental health as demonstrated by the frequent conflict between services rendered by primary care physicians and mental health professionals (Burns, Burke, & Kessler, 1981). Currently, the integration of behavioral managed care and physical health care is a major concern of those planning managed care systems. Also making system development difficult is the fact that existing funding streams have conflicting regulations and eligibility criteria (Dickey & Goldman, 1986).

Moreover, the lack of coordination directly affects clients. Tessler (1987) found that when clients do not connect with resources after discharge from inpatient care, their overall community adjustment is poorer and there are more complaints about them. On the other hand, poor coordination is sometimes blamed for failures actually due to insufficient resources or inappropriate services (Solomon, Gordon, & Davis, 1983). At some point, the sheer quantity of services (or lack thereof) does affect quality. Research has not yet clarified the relationship between the numbers, types, or coordination of services and client outcome.

Anthony and Blanch (1989) categorized various attempts at ensuring the integration of services into four types, according to whether they emphasized a) legislated relationships and program models, b) financing mechanisms, c) strategies for improving interagency linkages, and/or d) assignment of responsibility. Many initiatives have, of course, incorporated several of these elements.

Within the last several decades, data collection on systems level interventions has occurred sporadically. One example is the previously mentioned work of Harding (Desisto, et al., 1995a, 1995b) that involved comparing the long-term outcome of people with psychiatric disabilities served by two different systems in two separate states. This study concluded that differences in recovery outcome were probably due to system wide differences in psychiatric rehabilitation programming. Another example is the ongoing research investigating various Community Support System (CSS) services. In the 1990s the National Institute of Mental Health and later the Center for Mental Health Services (CMHS) initiated nationwide a number of research demonstrations of essential CSS service components, including vocational rehabilitation, case management, crisis response services, and other supportive services (Jacobs, 1998). An analysis of the results of 29 projects found that the majority of the studies reported positive findings on one or more of the following outcomes: symptomatology, consumer outcomes (e.g., competitive employment), satisfaction with services, and service utilization. More recent-

ly, ongoing CMHS demonstrations should inform system planners and policy makers into the next decade.

Another CMHS sponsored research initiative examined the impact of service integration on housing outcomes for persons who were homeless and mentally ill using data from the Access to Community Care and Effective Services and Supports (ACCESS) program (Cocozza, Steadman, & Dennis, 1997; Rosenheck et al., 1998). Results showed a significant relationship between measures of service system integration and independent housing outcomes.

A final example of systems level research is the effort launched by the Robert Wood Johnson (RWJ) foundation in the late 1980s. The RWJ initiative was based on the fundamental assumption that a central authority would enhance continuity of care, and that such improvements would lead to improved client outcomes. Nine cities were selected on a competitive basis to develop community-wide systems of care (Shore & Cohen, 1990). Within the 5-year demonstration period each city was expected to create a local mental health authority that would assume central responsibility for developing and coordinating public sector services. For the most part the RWJ system initiative did not attempt to improve practitioner competencies and program standards; rather, RWJ focused almost exclusively on organization and financing. Little significant consumer impact was found (Lehman, Postrado, Roth, McNary, & Goldman, 1994; Shern, et al., 1994).

Origin of the Recovery-Oriented System Standards

Unlike the development of standards for particular program models, there are no standards for recovery-oriented systems. Typically, standards have been most often considered in the development of model programs, such as Assertive Community Treatment (ACT), (Teague, Drake, & Ackerson, 1995), IPS (Becker & Drake, 1993; Drake, 1998), Clubhouse (Beard, Propst, & Malamud, 1982) and Choose-Get Keep (Anthony, Howell, & Danley, 1984; Anthony, Cohen, Farkas & Gagne, (2002). A comparable set of standards has not been advanced for a recovery-oriented mental health system. Furthermore, there is no model of a recovery oriented mental health system currently operating, although as pointed out previously, a number of systems are declaring the development of a recovery oriented system to be their intent. Direction and guidelines are needed to stimulate and reinforce the development of a recovery-oriented system. The system that existed for most of the last century was based on the notion that people with severe mental

Table 3. Characteristics of a Recovery-Oriented System

System Dimension	Recovery System Standard	Example of Current Nonrecovery Standard
Design	Mission includes recovery vision as driving the system	Mission includes description of service principles (e.g., continuity of care)
	Mission implies recovery measures as overall outcome for system (e.g., empowerment, role functioning)	Mission implies no measures of recovery outcome (e.g., comprehensive range of services)
	Core set of needed services are identified for system (e.g., treatment, rehabilitation)	Core set of programs or settings are identified for system (e.g., day treatment programs and inpatient settings)
Evaluation	Primary consumer outcomes identified for each service are measurable and observable (e.g., number of crises, percentage of people employed)	Outcomes for each service are process measures or program quality measures only (e.g., number of people seen in service; time before first appointment)
	Consumer and family measures of satisfaction included in system evaluation	Consumer and family perspectives are not actively sought for system evaluation
Leadership	Leadership constantly reinforces recovery vision and recovery system standards	Leadership vision is focused on developing specific programs or settings
Management	Policies insure that a core set of processes (i.e., protocols) are described for each identified service	Policies do not insure that service protocols guide service delivery
	Policies expect programs within each service to have policies and procedures directly related to implementing the service process	Policies and procedures are about staffing, physical setting, and so forth, and not about service process
	Policies insure that MIS system collects information on service process and outcomes	Policies focus MIS on collecting information on types of clients served and costs, but not on service processes and outcomes
	Policies insure that supervisors provide feedback to supervisees on service process protocols as well as on progress toward consumer goals	Policies on supervision do not focus on supervisors providing feedback on protocols and consumer goals; primarily on symptomatology and medication
	Policies encourage service programs to be recovery friendly (i.e., procedures are compatible with recovery values)	Policies encourage service programs to value compliance and professional authority

Table 3. Characteristics of a Recovery-Oriented System (page 2)

System Dimension	Recovery System Standard	Example of Current Nonrecovery Standard
Management *(continued)*	Policies encourage the assignment of service staff, to greatest extent possible, to be based on competencies and preferences	Policies direct service staff to be assigned primarily by credentials
Integration	Function of case management is expected to be performed for each consumer who wants or needs it	Case management function is not expected to be provided to all who want or need it
	Standardized planning process across services that is guided by consumer outcomes	Planning process varies between services, and is not guided by consumer outcomes
	Policies encourage the development and implementation of system integration strategies to achieve specific consumer outcomes	Policies on system integration strategies do not address development, implementation, and evaluation of such strategies
	Referrals between services include consumer outcomes expected of service provider	Service referrals include consumer descriptions rather than consumer outcomes
Comprehensiveness	Consumer goals include functioning in living, learning, working, and/or social environments	Consumer goals do not include functioning in living, learning, working, and social environments (typically only residential environment)
	Consumer goals include functioning in nonmental health environments, not controlled by the mental health settings (e.g., YMCA, religious organizations	Consumer goals emphasize adjustment in mental health environments
	Consumer goals include outcomes from any of the identified services	Consumer goals include outcomes for only a few of identified services
	Policies insure that programs provide an array of settings and a variety of levels of supports within a setting	Policies allow programs to provide a limited array of settings and supports within settings

Table 3. Characteristics of a Recovery-Oriented System (page 3)

System Dimension	Recovery System Standard	Example of Current Nonrecovery Standard
Consumer Involvement	Consumers are actively sought for employment at all levels of organization	Consumers are not actively sought for employment at all levels of employment
	User-controlled, self-help services are available in all geographic areas	User-controlled, self-help services are not available or available in only a few geographic areas
	Consumers and families integrally involved in system design and evaluation	Consumers and families are involved in a token way in system design and evaluation—if at all
Cultural Relevance	Policies insure that assessments, planning, and services interventions are provided in a culturally competent manner	Policies with respect to assessments, planning, and services intervention do not take cultural diversity into consideration
	Policies insure that the knowledge, skills, and attitudes of personnel enable them to provide effective care for the culturally diverse populations that might wish to use the system	Policies related to personnel do not attend to issues of cultural diversity
	Policies insure that settings and programs and the access to them reflect the culture of their current and potential consumers	Policies only insure that settings and programs are compatible with the predominant culture
Advocacy	Advocates for a holistic understanding of people served	Advocates primarily for particular programs, settings, or disciplines
	Advocates for consumers to have the opportunity to participate in community roles	Advocates for consumers to have the opportunity to participate in mental health programs
	Advocates for an understanding of recovery potential of people served	Advocacy for understanding of recovery potential of people served is lacking

Table 3. Characteristics of a Recovery-Oriented System (page 4)

System Dimension	Recovery System Standard	Example of Current Nonrecovery Standard
Training	Policies insure that all levels of staff understand recovery vision and its implications within service categories	Policies make no mention of recovery vision nor its implications for services
	Policies encourage selection and training methods designed to improve knowledge, attitudes, and skills necessary to conduct particular service that staff is implementing	Policies on selection and training based on interests of staff or training coordinator
	Policies insure that all levels of staff understand recovery vision and its implications within service categories	Policies make no mention of recovery vision nor its implications for services
	Policies encourage selection and training methods designed to improve knowledge, attitudes, and skills necessary to conduct particular service that staff is implementing	Policies on selection and training based on interests of staff or training coordinator
Funding	Dollars across services are expended based on consumers' expressed needs	Dollars across services are expended based on information other than consumer needs
	Dollars across services are expended based on expected process and outcomes of services	Dollars across services are expended based on historical, traditional funding
Access	Access to service environments is by consumer preference rather than professional preference	Access to environments is based primarily on professional decisions
	Access to service environments is not contingent upon using a particular mental health service	Access to service environments is contingent on participation in certain mental health services
	Access to living, learning, working, and social environments outside mental health system is expected	Access to living, learning, working, and social environments outside mental health system is not encouraged

illness do not recover, and that maintenance and care of people with severe mental illness should be the goal.

Lacking a currently functioning model system for guidance, it becomes necessary to suggest the system level standards that might be helpful for system designers. The recovery-oriented system standards outlined in Table 3 are meant to serve as a starting point of reference and as a guide for system development. Furthermore, the identification of system standards on which each system is based allow for system level research to be more meaningful. In addition, technical assistance for system development can use the standards as a jumping off point.

The particular standards identified in Table 3 are derived from several sources. First, they are consistent with the systems level research that has so far occurred. Secondly, they are compatible with the aforementioned recovery principles. Lastly, the system level consultants of the Boston University Center for Psychiatric Rehabilitation and its affiliate BCPR reviewed each standard and made changes to the standards based on their consultative experience. Standards were not included unless there was consensus. Over the last 17 years consultants from these organizations have on average provided technical assistance and training in about 17 states and three countries per year.

Recovery System Standard Dimensions

The standards have been grouped according to the system level dimensions which best describes the focus of the standard. However, this categorization of standards is done for ease of presentation and not as part of a deliberate attempt to characterize how system standards must be organized. As the standards are used, modified and refined, new ways to organize and name the system dimensions will no doubt occur.

Design

The mission and outcomes of the system incorporate the language of recovery. Consumers and their families are integrally important in the design process. The identified mission and consumer outcomes include such dimensions as improvements in role functioning, empowerment, consumer satisfaction, and quality of life. The mission is achieved through a set of identified services (see Table 2) which, when combined together, contribute to the achievement of the recovery outcomes (Anthony, 1993). A specific service (e.g., crisis intervention services, case management services) is defined by its unique process and outcomes. A setting is defined by its location (e.g., inpa-

tient, community mental health center). A program is defined by certain administrative, staffing, and service standards (e.g., intensive case management program, clubhouse program). The system is designed around the CSS configuration of services and is not designed around a specific set of programs or settings; rather programs and settings must indicate which of the services they provide and on what consumer outcomes they will be held accountable. For example, a PACT program may indicate that they provide treatment, rehabilitation, crisis intervention, and case management services, and that they are accountable for implementing the process associated with each of those services.

Evaluation

Each program providing services in the system must identify the unique consumer outcomes they will achieve. For example, in rehabilitation services, no matter what the rehabilitation program is called (e.g., IPS, Clubhouse) and no matter what the setting (e.g., psychosocial rehabilitation center, mental health center), the service must achieve improvements in the consumers' role functioning (see Table 2). Treatment services must achieve symptom alleviation, and so on. Outcomes assessments must always include the perspectives of consumers and family members.

Leadership

The vision of recovery must be present in most all of the leadership's written and public statements. Recovery is such a paradigm shifting notion (Anthony, 1991), that its fundamental assumptions and principles must constantly be reinforced. Recovery is a vision incompatible with the mission of the mental health system of the past century. The leadership must demonstrate through their words and actions that they and everyone else in the system need to "buy in" to this dramatically new direction.

Management

System management, through system level policies and procedures, must ensure that each individual service define itself by the unique process they use. Service protocols are developed and implemented so that the basic service processes are possible to monitor (Anthony, 1998). A management information system exists for each service. For example, the basic protocol for case management might include process components such as setting a service goal, planning, linking and negotiating for service access. The protocol for rehabilitation might include setting the overall rehabilitation goal, functional assessment, resource assessment, planning, skill development and resource development. Supervisory sessions revolve around effective ways to

implement the protocol. System management looks for "recovery oriented" values in the programs they fund, and staff assignment to programs is based, to the greatest extent possible, on competencies and preferences, rather than credentials.

Integration

The system polices include the provision of case management for all who need and want it. Each service, within the array of services offered by the system, has a standardized planning process that shares some common process elements across services, that is, each service contains the major process elements that are standard across services. Common process elements might be: an *assessment* of the consumer's goal(s), a *plan* to reach the goal(s), and specific *interventions* to achieve the goal(s). For example, enrichment services might perform an assessment to determine which enrichment activities the consumer prefers, plan how to access that activity, and intervene by providing or arranging the preferred recreational, social, and so forth activity according to the plan. Case management services might assess the person's service goal, plan for accessing those services, and intervene through linking and/or negotiating for those services. In addition, when referrals occur between different service programs, the referral includes a specific description of the consumer outcomes the receiving service is expected to achieve.

Comprehensiveness

All the possible residential, work, educational and social environments in which a consumer might potentially function are included as a consumer goal(s) and measurable consumer outcome(s). Functioning in nonmental health environments (e.g., schools, social clubs) are included as goals. It is the policy of the system that consumer supports that facilitate a consumer's functioning are provided in a wide variety of environments. A particular support exists in more than one environment. For example, intensive residential support may be provided in group residences, but also in an individual's own apartment.

Consumer Involvement

Selection and recruitment materials for staff throughout the system target consumers and family members for employment, as well as voluntary service on boards. User-controlled services are available in all the designated catchment areas served by the system.

Cultural Relevance

The system promulgates policies designed to increase the possibility that the system reflects the culture of the consumers served. Specifically, poli-

cies on cultural competence address the training and experience of practitioners, the assessment, planning, and intervention process, and culturally relevant programs and procedures to access them.

Advocacy

System advocacy occurs for the recovery vision, for a holistic understanding of the persons served, and for consumers to have the opportunity to participate fully in community roles.

Training

System level policies on training are designed so that delivery of specific services is improved; training is grounded in the vision of recovery, and not just in the interest of certain staff.

Funding

Funding from the system is based on the consumers' recovery goals. Funding directly supports the processes and outcomes that the system is designed to achieve.

Access

Policies encourage access to services based on the consumers' goals rather than professional preference. Access is not contingent upon the consumer attending certain mental health services. For example, access to housing is not contingent on taking medication. Access to nonmental health environments is expected.

Conclusions

As system planners use all or some of these standards they will undoubtedly modify, refine and/or add to these standards. This first attempt at providing recovery oriented system standards should prove useful in a number of ways. First of all, it can provide direction to system planners as they develop proposals for their system. It can provide a basis for consumer and family advocacy and monitoring at the system level. The standards can be used in system level research and evaluation of recovery oriented systems, and as a framework to make comparisons across systems. Lastly, as these standards outlined in Table 3 are put into use, it will further encourage the operationalization of these standards.

These recovery oriented system standards are a first step in moving a system with no recovery vision to a system that believes that consumers can develop meaningful and purposeful lives, despite having experienced the

catastrophe of severe mental illness. A mental health system guided by a recovery vision must have policies and procedures in place to increase the possibility of recovery occurring—for the system itself as well as for those it serves.

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Expanding the Evidence Base in an Era of Recovery

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Reprinted with permission from: Anthony, W. A. (2003). Expanding the evidence base in an era of recovery (Editorial). *Psychiatric Rehabilitation Journal, 27*(1), 1–2.

Prior to this decade's focus on evidence based practices, the last decade of the twentieth century witnessed the acceptance of the notion that people with severe mental illnesses could be integrated into and function within the natural community, rather than just the mental health community. Furthermore, recovery from severe mental illnesses was seen as a legitimate vision to guide mental health practice and policy. The vision of recovery from severe mental illnesses was brought to the field by the writings of current and former service recipients, and solidified by the long term research conducted and synthesized by Courtenay Harding and her colleagues. While many definitions of recovery have been suggested, the various definitions are somewhat similar in that they imply the development of new meaning and purpose in life as people grow beyond the catastrophe of severe mental illnesses.

A number of key principles are inherent in the recovery vision. One of the most fundamental recovery principles is the principle of "people first," i.e., people with mental illnesses are people before they are cases, diagnoses, or patients. They are not, as the mental health field has mistakenly emphasized, primarily defined and governed by their symptoms and their diagnoses. Rather, the principle of "people first" assumes that people with severe mental illnesses primarily direct their own lives like their non-diagnosed brethren. That is, they are influenced by their relationships with others, their own goals, their hopes, dreams, and interests.

While at first blush this people first principle may look benign and straightforward, the adoption of this principle has major implications for how the field of evidence based practices will develop. By incorporating this principle of "people first" into the field of severe mental illnesses, the knowledge base of what constitutes evidence will be expanded dramatically. Behavioral sciences research on the processes that bring about positive changes in all types of people (most of whom typically do not have severe mental illnesses) are now relevant to the evidence based practice initiative in the mental health field.

In this decade the evidence based practice initiative has designated certain practices as evidence based practices (e.g., supported employment, intensive case management) due to their ability to generate positive outcomes in

randomized trials. These evidence based practices are described mostly by their program structures (staffing, case load size, etc.). Unfortunately, the evidence based practice initiative has overlooked in these program descriptions the ingredients of the helping process that occur within each practice and which behavioral sciences research has shown to be related to how people change and grow (relationship variables, skill teaching strategies, hope engendering techniques). I argue that the evidence based practice initiative must be broadened to incorporate these empirically derived helping processes that are fundamental to people's growth and change, and which may underlie most evidence based program structures.

By definition, evidence based practice integrates "…individual clinical expertise with the best available external clinical evidence from systematic research…By best available external clinical evidence we mean clinically relevant research…" (Sackett, 1996, p. 71). With respect to the field of severe mental illnesses, "clinically relevant research" has often been confined to studies in the mental health services research arena. Yet the research literature on how people change and grow, not just people with severe mental illnesses but all types of people, is what is relevant under a "people first" principle. The behavioral science literature, supported at times by mental health services research has identified certain human interactive processes that help people change and grow. These processes include:

- People experiencing a positive relationship with the people providing help;
- People setting their own goals;
- People being taught new skills;
- People encouraged to have positive expectancies and hope for change;
- People developing self awareness about aspects of their own behavior.

I believe that any evidence based practice should incorporate any and all of these evidence based processes into their program structure. Without compromising fidelity to the program model, evidence based practices can promote a positive relationship between providers and recipients, help people set their own goals, teach skills, engender hope for change and promote self awareness. It is these evidence based processes that cut across program labels and which all types of research suggest can add outcome variance to the evidence based practice.

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The Recovery Effect

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Reprinted with permission from: Anthony, W. A. (2004). The recovery effect (Editorial). *Psychiatric Rehabilitation Journal, 27*(4), 303–304.

A recent *New Yorker* article coined the term the *Reeve Effect* to characterize Christopher Reeve's unrelenting pressure on the scientific community to transform how medical research is conducted (Groopman, 2003). Reeve, the actor who eight years ago was paralyzed from the shoulders down in an equestrian competition, has made small but extraordinary progress toward his own recovery. His success at gaining some movement below his shoulders mystifies many scientists who simply believed progress like his was impossible. With each new day, Reeve and other advocates pressure the scientific community to conduct research that is more relevant to improving the lives of people who have a disability. Reeve believes that people such as he must play a role in how the scientific establishment sets priorities, funds, and conducts its research. Does the Reeve Effect sound hauntingly familiar to what must happen in mental health research?

I would maintain that the mental health services research field will be increasingly challenged by what I would call the Recovery Effect. One hundred years of believing, without a solid research foundation, that severe mental illnesses were deteriorative over time, has come to a crashing end. In our field it has been the many people with psychiatric disabilities who have brought the vision of recovery to the forefront, aided by a few courageous researchers such as Courtenay Harding and her colleagues (e.g., Harding, Brooks, Ashikaga, Strauss & Brier, 1987; Harding, Zubin & Strauss, 1987).

It is now time for a Recovery Effect within our scientific community. We scientists have been prone to study pathology and symptoms, and as a result that is all we have found. The time to make a significant transformation in our research agenda is upon us. There must be a concerted focus of study on what makes people well, and what are the barriers and the facilitators to recovery. Our revolution in vision has to be followed by a revolution in science. To achieve this transformation mental health research must simultaneously become more caring, more fearless, and to think big thoughts. Guided by advocates and people with psychiatric disabilities, it is time to study how people grow and develop beyond the catastrophe of severe mental illnesses. The vision of recovery must permeate not only our practice but also our science; the Recovery Effect on the scientific community should be unremitting.

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Recovery: A Common Vision for the Fields of Mental Health and Addictions

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Reprinted with permission from: Gagne, C., White, W. & Anthony, W. A. (2007). Recovery: A common vision for the fields of mental health and addictions. *Psychiatric Rehabilitation Journal, 31*(1), 32–37.

Abstract: The vision of recovery is reshaping the fields of mental health and addiction services. This paper reviews how this broad vision is shaping common goals, principles, values and strategies across the two fields. We further examine how a common vision of recovery can positively impact the treatment of co-occurring disorders and speculate on how this vision can bridge the seeming differences between these two fields and reshape a mutual understanding of the essentials of recovery from severe mental illness and addiction.

In the field of mental health, the emergence of the recovery concept was supported by two divergent influences; the lived experiences of people living with and recovering from psychiatric disabilities, and research data that supported the fact that people with psychiatric disabilities do recover (Anthony, Cohen, Farkas, & Gagne, 2002). The recovery vision was introduced and most often discussed in the writings of people with psychiatric disabilities (e.g., Anonymous, 1989; Deegan 1988; McDermott, 1990; Ralph, 2000, 2004; Unzicker, 1989). Empirical support for the promulgation of the recovery vision in mental health has been by means of the synthesis and dissemination of numerous long-term outcome studies (Harding & Zahniser, 1994; Harding, in press), which suggested that a significant percentage of people with severe mental illnesses were dramatically improving over time. Currently, there are 10 national and international longitudinal studies of 20 to 30 years demonstrating that recovery is possible for at least one-half of people diagnosed with schizophrenia and other severe mental illnesses (Bleuler, 1972; Ciompi & Muller, 1976; DeSisto, Harding et al., 1995a, 1995b; Harding, Brooks et al., 1987a, 1987b; Hinterhuber, 1973; Huber, Gross & Schuttler, 1979; Kreditor, 1977; Marinow, 1974; Ogawa et al., 1987; Tsuang, Woolson & Fleming, 1979). Furthermore, a review of systems-level literature and mental health policy statements suggests that even though heretofore there has been no explicit consensus about the meaning of the term recovery, the vision of recovery is now guiding policies and practice in many state mental health systems (see for example, Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Jacobson & Curtis, 2000; Legislative Summer Study Committee of the Vermont Division of Mental Health, 1996; State of

Nebraska Recovery Work Team, 1997; State of Wisconsin Blue Ribbon Commission on Mental Health, 1997), as well as in entire countries like New Zealand (Lapsley, Nikora, & Black, 2002) and the United States (New Freedom Commission on Mental Health, 2003).

Concept of Recovery in Addictions: Current Perspective

In the addictions field, the use of the concept of recovery as an organizing construct for transformative change predates the rise of formal addiction treatment (White, 1998). The field's conceptual center has subsequently evolved through a focus on pathology (the study of alcohol and other drug (AOD) problems as medical diseases) to treatment (medical, psychiatric, and psychological interventions into AOD problems) to a re-emerging focus on recovery (prospects and processes for long-term resolution of AOD problems) (Morgan, 1995; White, 2004a; White, 2005). There is growing interest in the multiple pathways and styles of long-term recovery and in the international diversification and growth of addiction recovery mutual aid societies (Humphreys, 2004; White, 2004b). A new addiction recovery advocacy movement (see www.facesandvoicesofrecovery.org) led by recovering people and their families is calling for a reconnection of addiction treatment to the larger and more enduring process of personal and family recovery (Else, 1999; White, 2000). Frontier issues within this re-emerging recovery focus include struggles to define recovery and its conceptual and linguistic boundaries (White, 2002), efforts to measure the prevalence of addiction recovery in America (Road to Recovery, 1998), calls for a recovery research agenda (White, 2000), a shift from the current acute models of problem intervention to models of sustained recovery management (McLellan, Lewis, O'Brien, & Kleber, 2000; White et al., 2002) and the growth in peer-based models of recovery support services (Jason, Davis, Ferrari, & Bishop, 2001; White, 2004c). This renewed recovery focus is evident in the White House initiated Access to Recovery program, the Center for Substance Abuse Treatment's Recovery Community Support Program, and in state efforts to develop more recovery-oriented systems of care (see http://www.dmhas.state.ct.us/policies/policy83.htm).

Common Characteristics Between the Two Fields

The fields of mental health and addiction share a dark past in which people experiencing the psychiatric and/or addiction disorders endured institutions that offered ineffective, if any, treatment. Each disorder was considered to be intractable and stories of recovery were rare. People living with

either disorder were expected to end up in the least favorable places in society, the gutter, prisons, asylums, or morgues. Throughout history, both systems of care have been distracted by debates about the causes and nature of the disorders, troubled by widespread prejudice and discrimination, and undermined by the criminalization of behaviors associated with the disorders. Even today, addiction and mental illness occupy a common space of disgrace in society.

Examining the characteristics influencing recovery from addiction and recovery from mental illness, it is astonishing that the two fields have not collaborated to organize services under a common vision of recovery. (See Table 1). People living with psychiatric and/or addiction disorders want to eliminate or manage their symptoms, increase their capacity to participate in valued roles, and embrace purpose and meaning in their lives, in other words, experience recovery. People in recovery from mental illness and/or addiction disorders are leading the call to change the current service systems of care to become recovery-oriented.

The principles of a common recovery vision begin with the notion that for both disorders, recovery is a personal and individualized process of growth that unfolds along a continuum and that there are multiple pathways to recovery. First person accounts of people in recovery from addiction and/or mental illness have described recovery as a transformational process and an incremental process, and recovery stories are often filled with elements of both styles of change. First-person narratives of recovery from addiction and mental illness reveal the individualized nature of recovery processes. Also made clear within these stories is that people in recovery are active agents of change in their lives and not passive recipients of services. People in recovery from mental illness and/or addiction disorders also often note the important role of family and peer support in making the difference in their recovery.

The values of recovery-oriented mental health and addiction systems are based on the recognition that each person is the agent of his/her own recovery and all services can be organized to support recovery. Person-centered services that offer choice, honor each person's potential for growth, focus on a person's strengths, and attend to the overall health and wellness of a person with mental illness and/or addiction have a place in a recovery-oriented system. These values can be operational in all services for people in recovery from mental illness and/or addiction, regardless of the service type (i.e. treatment, peer support, family education etc.).

Table 1. Common Characteristics under a Recovery Vision

	Mental Illness	Addiction
Goals	To assist people affected by mental illnesses by reducing the impairment and disability, and improve quality of life.	To assist people affected by addiction disorders by reducing the impairment and disability, and improve quality of life.
Role of Person with Disability	Person is agent of recovery. Active involvement is necessary for recovery.	Person is agent of recovery. Active involvement is necessary for recovery.
Principles	Broad heterogeneity of population and outcomes Focus on person and environment Long-term perspective Recovery is a process and a continuum Non-linear process of recovery Family involvement is helpful Peer support is crucial Spirituality may be critical component of recovery Multiple pathways to recovery	Broad heterogeneity of population and outcomes Focus on person and environment Long-term perspective Recovery is a process and a continuum Non-linear process of recovery Family involvement is helpful Peer support is crucial Spirituality may be critical component of recovery Multiple pathways to recovery
Values	Person-centered Partnership (person involvement) Growth Choice Strengths perspective Focus on wellness and health	Person-centered Partnership (person involvement) Growth Choice Strengths perspective Focus on wellness and health

Differences that have existed in the recovery visions of the mental health and addictions fields could provide opportunities for synergistic growth in both fields (White & Davidson, 2006). For example, the addictions field has had a well-developed concept of full recovery but has lacked a legitimized concept of partial recovery, while the mental health field has long promoted the goal of partial recovery but has, until recently, lacked a viable concept of full recovery (Fisher & Ahern, 1999; White, Boyle & Loveland, 2004). Integrating the concepts of full and partial recovery within the emerging recovery visions of both fields holds great promise for shaping mental health and addiction services and supports.

Table 1. Common Characteristics under a Recovery Vision *(Continued)*

	Mental Illness	Addiction
Strategies to Facilitate Recovery	Treatment (i.e., crisis intervention, medication, therapy, illness management education) Community support (connection to peer-support and recovery organizations) Skills for valued roles Ongoing, flexible recovery-enhancing services Advocacy	Treatment (i.e., post-treatment monitoring, early re-intervention, medication, therapy Community support (assertive linkages to communities of recovery) Skills for valued roles Ongoing, flexible recovery-enhancing services Advocacy
Essential Ingredients of Recovery-Oriented System	Treatment Rehabilitation Peer support Community support Legal aid Enrichment Basic support Family education and support	Treatment Rehabilitation Peer support Community support Legal aid Enrichment Basic support Family education and support
Societal Attitudes	Historically, prognosis was considered hopeless Debates about cause(s) and nature of illness Criminalization of illness Prejudice and discrimination	Historically, prognosis was considered hopeless Debates about cause(s) and nature of illness Criminalization of illness Prejudice and discrimination

Reshaping the Future of Both Fields Under a Recovery Vision

Presently neither the mental health nor addiction treatment system is ideally designed to assist people in their recovery from mental illness and/or addiction. Both fields have had to acknowledge the limitations of the institutionally based "acute model" of treatment to bring about lasting recovery. Over the past 30 years, the mental health system has reorganized to offer support services in the community, while the addiction field continues to deliver primarily a model of acute care with little ongoing community support. Guided by a vision of recovery, the mental health and addiction fields could organize their services to address the often long-term and complex needs of people living with mental illness and/or addiction, including people severely disabled by co-occurring disorders. People who are living with co-occurring psychiatric and addiction disorders could be well assisted in service systems

united under a common vision of recovery through seamless participation in needed recovery-oriented services offered by both systems. Much has been written about the failures of the mental health system and the addiction system to provide people with co-occurring disorders with the long-term services and supports often needed to promote recovery (Drake et al., 2001, Minkoff, 1989, Mueser, Drake, & Noordsy, 1998). The vision of recovery would compel both systems to provide outreach to engage people in a process of recovery, motivational services to help people develop readiness for treatment and/or rehabilitation, and provision of ongoing recovery support services to assist people to reach their recovery goals. Recovery support services would be located in communities, in specific environments of need, and be provided by professionals, family members, and peers.

A unified recovery vision communicates realistic hope, emphasizes the role and responsibility of the person in recovery, and recognizes the many pathways to healing and wholeness that people with mental illness and/or addiction take in their recovery. The recovery vision could influence the research agenda to shifts its focus from acute pathology to the prevalence and processes (stages and styles) of long-term recovery from mental illness and addiction. The vision of recovery will require the mental health and addiction systems to work together with people in recovery as individuals and communities to develop effective services, strategies, and supports. Finally the recovery vision encourages the development of a culture of recovery and recovery communities to assist all people who are affected by mental illness and/or addiction, in other words, most of us.

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Resources on Recovery

Recovery Repository (http://www.bu.edu/cpr/repository/)

Numerous resources related to recovery are listed in the Repository of Recovery Resources on the Center for Psychiatric Rehabilitation, Boston University website (http://www.bu.edu/cpr/repository/).

Psychiatric Rehabilitation Journal (http://www.bu.edu/cpr/prj)

The *Psychiatric Rehabilitation Journal* has published several special issues and numerous articles related to recovery. Links to *PRJ* archives can be found at http://www.bu.edu/cpr/prj/ where you can search by typing "recovery" in the search field. PRJ articles related to recovery also can be found using a Google Advanced Scholar search. Special *PRJ* issues on recovery include:

Blanch, A. & Russinova, Z. (Eds.) (2007) Special issue on spirituality and recovery. *Psychiatric Rehabilitation Journal, 30*(4).

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Center for Psychiatric Rehabilitation Books and Publications (http://www.bu.edu/cpr/products/)

The Center for Psychiatric Rehabilitation has published a number of books related to recovery that are available at the website above, including:

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