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

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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.

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 classifi-

cation of the consequences of disease to provide the conceptual framework for describing the impact of severe mental illness (Frey, 1984).

Table1: 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, MA: Center for Psychiatric Rehabilitation.

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, 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

Table 2: The Negative Impact of 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: MA, Center for Psychiatric Rehabilitation.

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 multidimensional 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 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

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)*			✓	✓

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 recov-

ery 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."

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