

Mental health recovery paradigm: implications for social work. *Jenneth Carpenter.*

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Social workers have long been involved in developing, administering, and providing services for people with psychiatric disabilities. Critics of the system, including social workers and mental health consumer--survivor practitioners, have noted that the medical model has been a driving force in policy and services provision. This model is detrimental to consumers' self-efficacy and sense of hope and conflicts with a number of central social work values. The article argues that the values and beliefs of the consumer--survivor recovery movement are closely aligned with those of the profession, and that the movement offers social workers a more promising perspective from which to practice. The primary concepts and values of the evolving recovery paradigm are delineated, and implications for direct practice, administration, policy making, education, and research are discussed.

Key words

adult mental health

professional values

psychiatric disabilities

recovery

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Since the early years of the profession, social work has had a commitment to work with people who have psychiatric disabilities (Peterson et al., 1998). In movements that shaped both the profession and psychiatric services themselves, social workers in the early 20th century were involved in mental health care through direct practice, state-level advocacy, and policy development (Vourlekis, Edinburg, & Knee, 1998). Social work and mental health care have evolved considerably since that time, but the profession has consistently provided an invaluable contribution to this multidisciplinary field and the field, in turn, has helped define social work practice and its domain.

Today, many social workers continue to find employment in settings that serve people with psychiatric disabilities. A recent survey of NASW members revealed that

psychiatric hospitals were the primary work setting for 5.3 percent of the respondents and that 16.4 percent of respondents worked primarily in an outpatient mental health setting (Peterson et al., 1998). An additional 13.5 percent of respondents reported that an outpatient mental health clinic was their secondary employment setting (Peterson et al., 1998). Furthermore, given that psychiatric disability affects about 4.8 million adults in the United States each year (Kessler et al., 1996), it is reasonable to assume that even those social workers who do not work in mental health settings will at some point serve people who have psychiatric disabilities. Over the years, many varieties of services and treatment models for people with psychiatric disabilities have been developed. For instance, recommended services for people diagnosed with schizophrenia now include medication management, vocational rehabilitation, outreach/case management, and individual, group, or family therapy that is supportive and educational or targets behavioral and cognitive skills (Lehman, Steinwachs, & Co-Investigators, 1998a). A recent client survey indicates that of these services, those related to medication management are offered the most often (Lehman, Steinwachs, & Co-Investigators, 1998b). Rates of receipt of other recommended services ranged between roughly 10 percent and 45 percent among outpatient respondents (Lehman et al., 1998b).

Figures such as these do little to answer the concern that today's mental health system is founded in the medical model. Although medicine has clearly made vital contributions to the array of treatment options for people with psychiatric disabilities, near-exclusive reliance on this approach to services has been detrimental to the functioning of the system. Critics have argued that the system is preoccupied with the assumption that psychiatric disabilities are organic, biological diseases (Chamberlin, 1998), resulting in a vision of the client as a diagnosis rather than an individual (Deegan, 1996). Others have asserted this assumption is too frequently accepted as fact when research has yet to support it as anything other than a group of hypotheses and theories (Arben, 1996). Furthermore, the system has been said to endorse a concept of psychiatric disabilities as typically chronic and increasingly debilitating conditions, despite a long history of longitudinal studies that clearly suggest otherwise (Kruger, 2000). Ultimately, treatment too frequently focuses on symptoms and deficits, failing to recognize or engage the whole person (Rapp, 1998), and as a result dehumanizes the client (Deegan, 1996).

Such criticisms are indicative of a medical model of mental health and suggest an ideology and a services system that in many ways conflict with social work values. Social workers have been prominent among those who challenge the medical model; perhaps social work's most significant contribution to this movement has been the use of the strengths perspective in the development of a model of case management for people with psychiatric disabilities (see Rapp, 1998). Much of social work practice, however, continues to be informed by an orientation to deficit and disease (Saleebey, 1997). This is not surprising, given that social work is just one of a number of professions that make up the mental health system and that the system as a whole is supported and sanctioned by a society that holds medical science in particularly high esteem. Social workers must continue to operate within this system, but by doing so they should adopt a practice stance that, true to the values of the profession, advances client empowerment and celebrates the individual. Such a stance would once more redefine social work practice and the profession's unique contribution to the mental health services system. The recovery movement, driven largely by mental health consumer-survivor participants, offers an ideal paradigm for this purpose.

This article argues that the recovery paradigm is highly compatible with social work values and that, among the mental health professions, social work is uniquely qualified to both support and use this paradigm. The concept of recovery is contrasted to the concept of chronicity. The article briefly delineates the history of the recovery movement, examines the principles of its perspective, addresses the perspective's relevance to social work values, and makes suggestions for incorporating its principles into social work practice.

CONCEPT OF CHRONICITY

Mental health services have long been designed around the assumption of chronicity of psychiatric disabilities. Kraepelin (1856-1926) was the first to describe and study what we now call schizophrenia, and chronicity was intrinsic to his definition of the disorder (Kruger, 2000). The first Diagnostic and Statistical Manual of Mental Disorders (DSM), published in 1952 by the American Psychiatric Association, described schizophrenia as a disease of ongoing deterioration (Kruger, 2000). DSM-IV (1994) still states that progressive deterioration can be expected for a subset of those diagnosed with schizophrenia and cautions that complete remissions are rare

(Kruger, 2000). Diagnostic criteria tend to rule out individuals who improve, particularly those who do so relatively quickly (Kruger, 2000).

Jimenez (1988) further argued that the medical model itself has contributed to our current perception of mental illness as a chronic disorder. Psychiatrists and other providers practicing early in the model's inception had few, if any, effective treatments to provide. Because the medical model indicated that recovery was deemed possible only through medical services and that these services did not help anyone recover, it was reasoned that these disorders had to be chronically debilitating (Jimenez).

Research does not support the assumption of chronicity. Longitudinal studies completed as early as the 1970s and 1980s suggest that many, if not most, people diagnosed with schizophrenia and other psychiatric disabilities do experience either complete or significant remission of symptoms, work, have relationships, and otherwise engage in a challenging and fulfilling life (Kruger, 2000). In 1975, Huber, Gross, and Schuttler reported on a long-term follow-up study of over 500 adults who had been diagnosed with schizophrenia. Of this sample, more than one-fifth enjoyed complete remission of symptoms and more than two-fifths had experienced significant, partial remission of symptoms (Huber et al.).

In a 30-to-40-year follow-up study, Tsuang, Woolson, and Fleming (1979) found that roughly 46 percent of individuals diagnosed with schizophrenia had no symptoms or had only moderate (nonincapacitating) symptoms. Furthermore, about 43 percent were either working at the time of the study or were unemployed because of physical, rather than psychiatric, disability (Tsuang et al.). The third phase of the Vermont Longitudinal Study, released in 1986, echoed these earlier findings. In this 20-to-25-year follow-up study of former state hospital patients, 72 percent were considered to have slight or no psychiatric symptoms, and 65 percent were found to be either employed, working in the home, or retired or elderly (Harding, Brooks, Ashikaga, Strauss, & Breier, 1986a, 1986b).

More recent research suggests that the course of schizophrenia and other serious mental illnesses varies by individual (Surgeon General, 1999; Wiersma, Nienhuis, Slooff, & Giel, 1998). Although it follows that outcomes for the population will be mixed, these studies do not support a chronically degenerative model of mental illness. For instance, a longitudinal study of young adults diagnosed with

schizophrenia did not yield outcomes as positive as those found by Harding et al. (1986a, 1986b) and also did not find a subgroup that could be defined by ongoing deterioration (Harrow, Sands, Silverstein, & Goldberg, 1997). In fact, frequency of hospitalization decreased during the later observations of this study, and by the final observation there was no significant difference in social functioning between the experimental and control groups, which comprised individuals with a variety of other mental health diagnoses (Harrow et al., 1997). Other longitudinal studies focusing exclusively on cognitive functioning in people with schizophrenia have found that, even on this dimension, the most common outcomes are stability and improvement (Mirsky et al., 2000; Rund, 1998).

Despite findings such as these, the premise of chronicity continues to be widely accepted in the mental health system, and dismal prognoses continue to be communicated to people with psychiatric disabilities (Kruger, 2000). These prognoses leave little room for a sense of hope on the part of those labeled with mental illness and, as such, may become a self-fulfilling prophecy (Jimenez, 1988). The consumer-survivor recovery movement has sought to restore that hope with an innovative perspective on the meaning and course of psychiatric disability (Kruger, 2000).

CONCEPT OF RECOVERY

Throughout the 1980s, consumer-survivors, many of them accomplished mental health professionals themselves, gave voice to the recovery vision by publishing accounts of their own recovery in professional journals (Anonymous, 1989; Deegan, 1988; Houghton, 1982; Leete, 1989). In 1993 psychiatric rehabilitation authority William Anthony challenged the mental health services system to make the recovery vision their practice guide for the 1990s (Anthony, 1993). This challenge was heard, and consumer-survivors, professionals, and researchers began to explore the process of recovery and define the recovery paradigm. Today the paradigm continues to evolve, but a number of central beliefs, values, and concepts are common to most of the recovery literature (Bullock, Ensing, Alloy, & Weddle, 2000). The most fundamental premise of the recovery paradigm is that people with psychiatric disabilities can and do recover. This vision is a challenge to professionals' message to expect less from a life affected by mental illness (Frese & Davis, 1997). In addition, it springs from dissatisfaction with the medical model's

declaration of symptom relief as the primary and ultimate goal of mental health services (Anthony, 1993; Frese & Davis). The recovery vision suggests a positive goal in place of a negative one: Rather than attempting to reduce the risk of relapse, the individual in recovery works to achieve personal success (Sullivan, 1994). The vision describes a life beyond psychiatric diagnosis that is both vital and valuable, whether or not symptom relief is ever achieved (Anthony; Deegan, 1988; Frese & Davis).

Recovery has been described as a process rather than discrete result (Anthony, 1993; Deegan, 1988, 1997; Frese & Davis, 1997; Pettie & Triolo, 1999; Sullivan, 1994). It is an active process. The individual assumes responsibility for her or his own recovery (Deegan, 1996; Fisher, 1994; Leete, 1989). Self-determination is essential (Deegan, 1988, 1996, 1997), and the concrete skills an individual discovers in recovery are skills of self-management (Leete; Sullivan).

As suggested in the earlier discussion, the recovery process is driven by the hope that the individual can build a life worth living (Anonymous, 1989; Anthony, 1993; Deegan, 1988, 1996; Fisher, 1994; Frese & Davis, 1997; Houghton, 1982; Russinova, 1999; Young & Ensing, 1999). It has been argued that this hope is frequently nurtured internally by the perception that a person has strengths and resources necessary to reach her or his goals (Russinova, 1999) and externally by a supportive relationship (Deegan, 1988; Russinova, 1999). Such a relationship may be with a professional, friend, or family member who can be hopeful when the consumer cannot and can share both successes and setbacks (Anthony; Deegan, 1988, 1996; Houghton; Sullivan, 1994; Young & Ensing). Proponents of the recovery model argue that it is exactly this sort of hope that is extinguished by the medical model and the assumption that chronicity is an unavoidable aspect of psychiatric disability (Deegan, 1996, 1997).

Recovery is a highly individual process. It is a search for a unique and positive sense of who one is (Davidson & Strauss, 1992; Deegan, 1996, 1997; Frese & Davis, 1997; Pettie & Triolo, 1999; Young & Ensing, 1999). In addition, although some consider the acceptance of the disability to be vital to the recovery process (Anonymous, 1989; Deegan, 1988; Sullivan, 1994; Young & Ensing), it remains up to the individual to define the illness and its meaning in her or his life (Leete, 1989; Pettie & Triolo). Mental health consumers engaged in recovery may therefore find themselves

challenging traditional perceptions, assumptions, and terms relating to psychiatric disability and its symptoms (Deegan, 1997).

Given the individual nature of recovery, it follows that the process is dependent on consumers having options and choices (Fisher, 1994; Leete, 1989). Services and supports are chosen by the individual and used as tools (Deegan, 1996, 1997). Informal or nontraditional supports may be integral to the recovery process. For instance, many individuals find that spirituality enriches or facilitates recovery (Fallot, 1998; Sullivan, 1998). In fact, recovery can occur without the use of the traditional mental health system and medications if the individual so chooses (Anthony, 1993). The recovery process is not linear. Rather, it is a path consisting of multiple types of experiences--of steps forward and of setbacks (Anthony, 1993; Deegan, 1988, 1996). What would be considered regression or decompensation in the medical model is instead an opportunity to learn or to regroup (Deegan, 1988; Russinova, 1999).

Finally, as suggested by the consumer--survivor definition of the experience of psychiatric disability, the process is as much about recovery from the societal reaction to the disability as it is about recovery from the disability itself. This reaction includes the marginalization people experience secondary to the stigma of the illness (Anonymous, 1989; Anthony, 1993; Davidson & Strauss, 1992; Leete, 1989) as well as the poverty into which most individuals are forced following the onset of their illness (Deegan, 1996; Houghton, 1982). Not surprising, some suggest that the development of a critical consciousness of societal response to mental illness is an important part of the recovery process (Fisher, 1994; Leete).

EMPIRICAL SUPPORT

To date, there has been relatively little investigation into the recovery process and interventions or other factors that promote it (Ridgway, 2001). A number of researchers have applied qualitative methods to consumer interviews and testimonials to begin developing a theoretical framework (see, for example, Jacobson, 2001; Ridgway, 2001; Smith, 2000; Sullivan, 1994). Others have created recovery-related measures and instruments (see Ralph & Kidder, 1999). Given that these areas of research are still in the early stages of development, it is not surprising that there are as yet few outcome studies of services that are specifically intended to facilitate recovery.

Those that do exist are generally promising. For instance, Bullock, Ensing, Asloy, and Weddle (2000) studied the effects of participation in a leadership-training program designed to prepare participants to serve on mental health agency boards and thereby promote recovery through personal empowerment. Participation in the program was associated with decreased symptoms, increased sense of self-efficacy, and increased community living skills (Bullock et al.). Anecdotally, we have noted that many of the participants were either working for mental health agencies or serving agencies in an advisory capacity at the six-month follow-up (Bullock et al.). There is also empirical support for consumer-operated services and mutual aid organizations (Davidson et al., 1999; Humphreys & Rappaport, 1994), which are widely considered to aid consumer empowerment and recovery. For example, Yanos, Primavera, and Knight (2001) found that participation in consumer-operated services was associated with increased self-esteem, sense of self-efficacy, and general community participation. Results such as this support the consumer-defined recovery vision and encourage continued attention to that vision.

RECOVERY PARADIGM AND SOCIAL WORK VALUES

The agreement between the recovery movement and social work values may be illustrated through an examination of the profession's guiding principles--NASW's Code of Ethics (2000). Such an examination reveals that the central tenets of the recovery movement are supported by social work values, most notably those of consumer empowerment, self-determination, worth of the individual, and concern for the environmental role in personal experience.

Concern for the empowerment of oppressed people is a principle value of social work. The Code relates this concern to what is described as the "primary mission" of the profession, the facilitation of human well-being (NASW, 2000). Empowerment also is linked to one of the six core values described in the Code, that of social justice (NASW). The recovery movement, as a reaction to a philosophy and system that has too frequently oppressed its consumers, is founded on this same value. Furthermore, as consumers initiated and continued to drive the recovery movement, the movement itself embodied empowerment.

Interest in self-determination is closely linked to that in empowerment. The core social work value of belief in the dignity and worth of the person requires social workers to support consumer self-determination (NASW, 2000). Self-determination is

intrinsic to the recovery paradigm, given its focus on consumer choice and the consumer as the director of his or her recovery process. The profession's emphasis on the worth of the individual is in keeping with other aspects of the recovery movement's philosophy as well. Most notable among these aspects is the movement's concern for the development of each individual's unique self. Finally, social work's operating framework--that of the person-in-environment--supports the philosophy of the recovery movement. As noted earlier, the movement has helped bring to light the profound effect that being labeled with a psychiatric disability has on the individual so labeled. This is in stark contrast to the medical model, which focuses primarily on symptoms and disorder within the individual, regardless of the poverty, discrimination, and isolation that so many people with psychiatric disabilities face every day.

IMPLICATIONS FOR THE PROFESSION

The NASW Code of Ethics (2000) identifies the following as activities that constitute social work practice: direct practice, community organizing, supervision and administration, advocacy and policy-making, teaching, and research. The literature regarding the recovery paradigm suggests basic values, assumptions, and guidelines for each of these activities of social work practice.

Direct Practice

As recovery is an active process, directed by the individual, the goal of direct practice is not for the practitioner to "recover" the client but instead to support his or her recovery process (Deegan, 1988). This can be accomplished by providing an environment that is rich with what Anthony (1993) termed recovery "triggers." Perhaps the most basic of these triggers is the information that many people with psychiatric disabilities do recover. Social workers should disseminate this information to all clients who have psychiatric disabilities and engage these clients in discussions of the relevant research as well as evidence of recovery from the workers' own practice experience (Kruger, 2000). A second related trigger is the provision of accurate and thorough information regarding services and treatment options (Deegan, 1996). Only through such information can the consumer begin to exercise self-determination and choice (Deegan, 1996). It follows that the practitioner also must offer a variety of services so that the consumer has the opportunity to exercise choice (Deegan, 1988; Fisher, 1994). That variety should include traditional services,

such as medication management and therapy, as well as innovative methods, like mutual aid groups (Deegan, 1988).

However varied the services offered, recovery is unlikely to happen through the mental health system alone, and resources for recovery abound outside the system. Consumers in recovery have spoken of the importance of friends, family, work, school, churches, hobbies, and get-togethers (Smith, 2000; Sullivan, 1994). Social workers, practicing from the person-in-environment perspective, are ideally situated to support consumers recovery by helping them to connect or reconnect with these invaluable resources. This process may be formal or informal according to the consumer's preference. A strengths assessment is one tool consumers and workers can use to identify and map a wide range of naturally occurring resources (Rapp, 1998).

Related to this is the importance of the clinician's recognition that there are many paths to recovery. Choosing not to participate in the formal mental health system should not be labeled "denial" or "noncompliance" (Anthony, 1993). When working with a consumer who is considering engaging in the recovery process without the mental health system, the practitioner should first investigate whether services can be altered in such a way that they might become more helpful. As described earlier, the practitioner also should engage the consumer in a discussion of supports to recovery that already exist in the consumer's life outside the services system and how those supports may be best used to facilitate the recovery process with or without the formal mental health system.

In addition, practitioners should consistently view consumers as individuals who have strengths and the potential to grow and should consistently convey that vision to consumers (Rusinova, 1999). The aforementioned strengths model offers clearly developed techniques for recognizing strengths, communicating that recognition to consumers, and using strengths to develop goals and objectives (Rapp, 1998). Deegan (1996) recommended that practitioners take time to earnestly self-reflect on the processes that they themselves have undergone in struggling to recover from loss or hardship in their own lives, such as divorce, death of a family member, or serious injury. Such reflection should build a heartfelt appreciation for the consumers strength and tenacity (Deegan, 1996). With this appreciation, the practitioner can begin to convey the all-important sense of hope to the client.

Administration, Advocacy; and Policy Making

The recovery paradigm has implications for all aspects and levels of mental health systems (Anthony, 2000). Social workers can advocate for recovery-supporting policy change throughout their local system, using as models the changes that a number of states have implemented. Consumer -- survivor involvement in all levels of the services system is a prerequisite (Fisher, 1994). Some states have worked toward this by opening consumer positions within the system, creating recovery work groups of consumers and policymakers, and employing consumers to train policymakers and professionals on recovery issues (Jacobson & Curtis, 2000). A few states are using a recovery orientation to reconsider more controversial or complicated areas of policy, such as involuntary care and informed consent (Jacobson & Curtis, 2000). Social workers should support these efforts and advocate for a policy that reflects the recognition that deciding not to participate in the formal treatment system is indeed a legitimate choice. Also, by advocating for improved resources for financially disadvantaged people, social workers can continue to work on behalf of people with psychiatric disabilities who choose not to use the system. Greater availability of affordable housing, vocational training, and other community resources ultimately can provide an environment that better facilitates recovery both for those who use the mental health system and those who do not.

Managed care now affects the greatest proportion of mental health policy and services delivery. It has been argued that, despite potential pitfalls, managed care can be used to facilitate a mental health system's adoption of a recovery orientation (Forquer & Knight, 2001). Some states have incorporated clauses about recovery in their managed care contracts (Forquer & Knight). Given that it eliminates the impetus to overserve, managed care can help structure a system that recognizes the value of natural supports and promotes the use of those supports (Forquer & Knight). These supports maybe completely separate from the mental health system or may be organized consumer-operated services, such as mutual aid groups and drop-in centers (Forquer & Knight).

Consumer-operated services are thought to promote recovery and have empirically demonstrated positive outcomes. Therefore, social workers should support and advocate for such organizations. Some states now offer funding, training, and access to other resources for consumer-operated organizations (Jacobson & Curtis,

2000). Concern has been raised that such support has the potential to jeopardize the mutual-aid values and mission of many consumer-operated organizations (Jacobson & Curtis). Social workers should familiarize themselves with the consumer-run organizations in their system, and should learn about the needs and concerns of the organizations from the people who run them.

Education

Social work educators can support the recovery movement in a number of ways. Like policy, curriculums should reflect the assumption that recovery can and does occur and that consumers are the agents of their own recovery. Students should be informed of research that supports this assumption, such as the longitudinal studies discussed earlier. In addition, they should be challenged to think critically about their own assumptions about the nature of psychiatric disability, as well as the attitudes reflected by the services system, policymakers, and the public. The history of the consumer-survivor movement and its values and principles should be covered in all mental health practice and policy courses. Finally, social work educators should incorporate consumer-survivor perspectives into their courses through the use of assigned readings written by consumers and guest lectures by consumers.

CONCLUSION

The perspective of the recovery movement challenges the medical model and the assumption of chronicity that too frequently permeate mental health services. The recovery perspective is grounded in concern for the empowerment of an oppressed population, a belief in the right of all individuals to self-determination, and an understanding of the effect of the environment on the experience of people who have psychiatric disabilities. Social work is in a unique position among the mental health professions and is ideally situated both to support this vision and to develop within it. Social workers are well-suited to the tasks of answering the mandates of the recovery paradigm: supporting people as they draw on natural resources in their environments; operating from the perspective that all consumers have both profound immediate worth and the potential for tremendous, self-defined growth; advocating for meaningful system change at all levels; and working toward community change and enrichment that will facilitate the recovery of all people with psychiatric disabilities, including those who choose not to use the formal helping system as they engage in their recovery process. Therefore, the recovery paradigm offers social

workers a perspective that upholds the profession's values and may be used as a foundation for direct practice and agency administration, a guide for policymaking, and a theoretical base for mental health research. By embracing the recovery vision as its primary mental health practice perspective, social work could once again define its distinct professional role while simultaneously engaging with consumers in redefining the mental health system.

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