

Introduction to

EMPOWERMENT AND RECOVERY

IN MENTAL HEALTH

PRESENTATION WORKBOOK

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Partnership *for*
Consumer
Empowerment

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Foreword

Partnership for Consumer Empowerment, along with the Manitoba Mental Health Education Resource Center, is a program of the Mental Health Education and Empowerment Initiative funded by Manitoba Health.

The purpose of the initiative is to:

1. Improve understanding of the principles of empowerment and recovery and the impact of these concepts for consumers, family members, friends, and service providers;
2. Increase awareness of the consumer role in their recovery;
3. Promote mental health, and educate about mental illness in an effort to encourage Manitobans to seek treatment early and to reduce the prejudice and discrimination that exists towards people with a mental illness.

Background

In response to a need for an educational program defining the principles of empowerment and recovery, and the potential impact of these concepts in peoples' lives, the Manitoba Provincial Advisory Committee for Mental Health Reform initiated the development of a consumer empowerment program in 1993/94. The educational program was developed and delivered by consumers of mental health services. Originally housed at Manitoba Health, the program has evolved into a community-based initiative, providing workshops throughout the province of Manitoba as well as consultation, advocacy, and other support services.

The mandate of this program has been reaffirmed and expanded through Manitoba Health's Mental Health Renewal Plan. The purpose of the Partnership for Consumer Empowerment program is to:

1. Improve understanding of the principles of empowerment and recovery, and the impact of these concepts for consumers, family members, friends and service providers.
2. Increase awareness of the consumer role in their recovery.
3. Build consumer capacity and participation.

Program Vision Statement

All people living with mental health challenges in Manitoba have the knowledge, skills, resources, supports, and opportunities they require for their recovery; and for meaningful participation in the planning, delivery, and evaluation of mental health services.

Program Principles

- RELEVANT
- CURRENT
- INNOVATIVE
- EMPOWERING
- HOPEFUL
- CHALLENGING
- CREATIVE
- RESPONSIVE
- FLEXIBLE
- PRACTICAL

The **purpose** of the **Partnership for Consumer Empowerment** workshop is to invite people to participate in the change of ideology; to clarify the meaning of terminology; to increase awareness of consumers' and families' changed expectations in attitudes, beliefs, and behaviors; to promote change in mental health service delivery; and provide people with psychiatric disorders opportunities to improve their health and restore hope in their lives. A major objective is to challenge people to examine their own attitudes and beliefs – to become aware of them in order that they may be open to change.

In 1988, after decades of effort and commitment on the part of many people, the process of mental health reform was initiated in Manitoba. Since that time many changes have occurred in the structure of our mental health system but much remains to be done to significantly alter the mental health environment.

Despite the assumptions of many people, the process of mental health reform in Manitoba was never intended to be simply a cost saving exercise. The objective was to make mental health services much more appropriate, accessible and responsive to the needs of people with mental illnesses and their families. Although substantial progress has been made in some respects, little significant change has occurred in other crucial areas. The attitudes, assumptions, violations of people's rights, and the discrimination attached to mental illness continue to foster a hostile environment, not only in society as a whole, but within the health and human services fields, including mental health.

Over the decades, different words have been used to describe people and processes. However, changing the words did little to improve the reality for people coping with mental illness. With mental health reform, words such as recovery, empowerment, integration and partnership became common currency. Unfortunately, many that used the words did and still do not understand their meaning. Words like consumer and survivor were adopted for a reason but they too simply became new labels with their meaning only understood by those who used and continue to use them.

Substantial change in the environment requires shifts in attitudes, beliefs, and behaviors – not just language and programs. The balance of power, which determines the relationship between service providers and their clients, must be revised. However, meaningful change can be terrifying, even for those who believe they truly want change. The tendency is to settle for superficial changes: "It's like we keep rearranging the deck chairs on the Titanic but all we achieve is a different view while going down." (Patricia Deegan). That (*this tendency*) is the pitfall of simply using the newest program designs and politically correct language.

The "new vision" for mental health was intended to create change in the areas of power and accountability – not to reproduce institutional approaches in community settings. The objective was and continues to be the establishment of a new way of doing business.

Consumers and their families are no longer prepared to settle for a dehumanizing system that has given up hope; that has become hostile and blames us for our difficulties. We are no longer prepared to accept the distance and isolation imposed on us by a system that has "gatekeepers" whose job it is to "screen" and "divert" service users. We are tired of being labeled chronic, apathetic, unmotivated, and treatment resistant. Simply changing the location where services are delivered will not resolve the situation. We need to ensure that people are aware of and understand the ideological basis for change.

Much of the change in mental health comes from the consumer movement's focus on empowerment and recovery. The concept of empowerment is related to social justice. This means that people should have all the information they require and be provided with the opportunity to make informed choices and decisions – to be in control of their own lives. It means that consumers have a voice to speak for themselves – to define their needs and solutions. The focus on health and recovery means that services must recognize the strengths and experiences that individuals with mental illness bring with them and find ways to build on these strengths.

Consumer empowerment and the relevant education of service providers, family members, other natural supports, and consumers is key to a successful paradigm shift. It is essential that people with a mental illness 'own' their own lives, including their challenges, problems, and solutions. Ultimately, successful recovery is determined by the degree of self-empowerment that a person has. Service providers, families, natural supports, and others need to know how to assist people in mental and emotional distress to become more successful in living with and *beyond* their illness. The best source of this information is consumers themselves.

The material in this workbook has been prepared as a supplement to the Partnership for Consumer Empowerment workshops.

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Value and Beliefs

Let us begin with an examination of our values, and our implementation of those values. The principles of empowerment and recovery require a clear and concise understanding and commitment to those principles if we are to be effective helpers. We also need to be aware of our attitudes and beliefs about mental illness and the people affected by these disorders. Our attitudes and beliefs will define how we respond to persons with mental health difficulties.

Providing services in mental health, as in any helping field, means we have ***chosen to serve*** people with mental and emotional health challenges. Serving others effectively demands that we put our personal agendas, attitudes, biases and fears aside and let ourselves be directed by the people we have ***chosen to serve***.

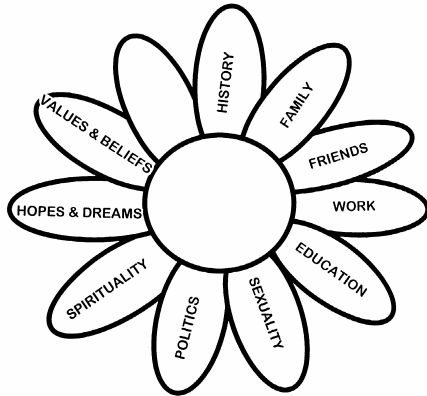
For those of us that have landed in the mental health system by circumstance rather than by choice, it is essential that we also perform a thorough examination of our beliefs and values. Whether we are service providers or service recipients – the outcomes we strive for and those we achieve are determined by the potential or limitations we place on others and ourselves.

We are faced with the tragic reality that finds much of society including many consumers, family members and service providers viewing mental illness and the people consumed by these illnesses with fear, abhorrence, prejudice and discrimination. This discriminatory attitude is the greatest barrier to successful recovery.

Describe an example of the barrier of discrimination / stigma in mental health which you have observed, experienced or heard about. How did this situation impact the people involved? How did it impact you? What, if anything, did you do to address the situation?

Values and Beliefs

PICTURE THE FLOWER REPRESENTING THE PERSON



THE FLOWER PETALS REPRESENT VARIOUS PARTS OF THE PERSON.

1. Where would you place an illness like schizophrenia on the flower? Why?

2. Using the flower, reflect on how your “petals” combine to define you as a beautifully unique individual. What events, characteristics, or experiences stand out on your flower?

3. What are your unique challenges? Where do you place them on your flower?

4. How has this exercise impacted on your views of people with mental illness?

Impact of Mental Illness

Mental illness begs to be understood in all its complexity. Effective, person centered, empowering, recovery focused helping requires an understanding of mental illness that is sensitive to the sociological, psychological, spiritual, emotional, cultural, biological, environmental, and experiential aspects and perspectives of mental illness. It is only when we understand the diversity and complexity of the dramatic impact these disorders have on people's lives that we can begin to envision the creativity, flexibility, diversity, and ingenuity required of our helping systems.

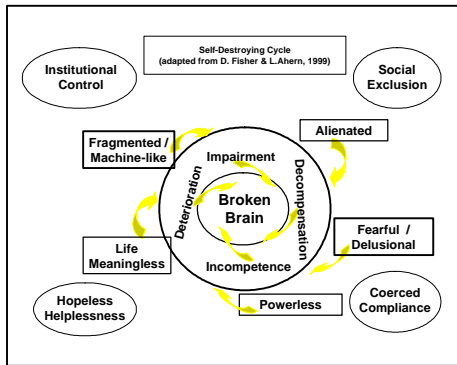
This is the essence of the difference between mental illness and all other illnesses – symptoms (of mental illness), though seemingly overwhelming and consuming at times, represent only a fraction of the real impact on people's lives.

From your experience of working with people or your understanding of mental illness, how does the illness impact on people and their lives?

In answering, consider the following:

- Self-concept
- Self-efficacy
- Hopes and Dreams
- Emotional Impact
- Major Social Roles
- Engagement with "helping systems"

Disempowerment



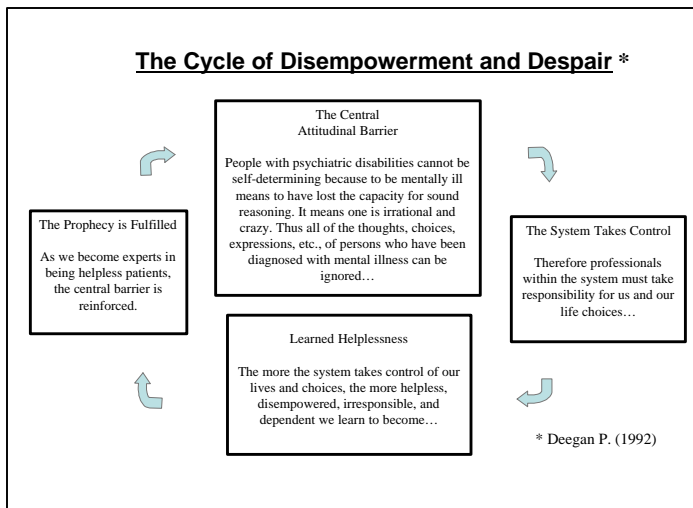
The impact of disempowering values and systems can be seen in the self-destroying cycle. The self-destroying cycle represents the paradigm of institutional expertise, ideology and power. The “ill” person is incapable of thinking, deciding, or acting in his/her own best interest. It is the cycle that **consumes** the individual, leaving only helplessness, hopelessness, irresponsibility, and dependency.

This cycle graphically illustrates the reality and outcome of the cycle of disempowerment and despair (see next slide) described by Patricia Deegan in her article “The

independent living movement and people with psychiatric disabilities”. (1992) *Psychiatric Rehabilitation Journal*, 15(3). P 3-19.

The promotion of mental illness as “brain disease” and the programming of people within the psychiatric system into this doctrine, creates a belief and value system accepted by the “ill” and institutionalized person that perpetuates a cycle of debilitation, deterioration, and impairment. It is a cycle that crushes the person, physically, mentally, emotionally and spiritually.

Cycle of Disempowerment and Despair



The purpose of the consumer empowerment movement in mental health is to destroy this cycle; promote social justice, compassion, and patient/survivor rights; and enable people to regain their right of self-determination, dignity, autonomy and self-respect.

A significant barrier to this movement is found in old-paradigm practitioners. “We don’t need a new paradigm, they believe, we just need to make the one we have work better... Blame certain people, and label them as

troublemakers. We need more discipline, more restraints, and more laws with stricter enforcement.” (Breton & Largent, *The Paradigm Conspiracy*. 1996).

Breton and Largent go on: “In other words, according to the prevailing paradigm, coming down hard on people isn’t abuse. It’s how we create healthy families, schools, businesses, governments, and churches, because it rids us of the sinful, ignorant, or otherwise unruly souls that muck up the social machinery. If things don’t work, the solution is to take away more rights, stifle more creativity, intimidate more people, build more prisons, and bring back the death penalty. More fear keeps people in line.” (p.8)

Attitudes and approaches described by Breton & Largent and in Deegan’s cycle of disempowerment and despair illustrate the strategy opposed by the consumer empowerment

movement – the strategy of reducing personal pain to problem behaviour requiring management through power and control.

Have you encountered / observed this strategy? What impact did it have on the people involved? What impact did it have on you?

Breaking this cycle involves taking risks. Consumers who battle this cycle face tremendous risks, including the risk of having their resistance viewed as treatment resistant and non-compliant behavior; stress and burnout; more negative labels (“loose cannons”, “extremists”), etc. Being a helper also means being an advocate when necessary – a role that may require the helper to take personal risks. Are you prepared to take risks? How much are you prepared to risk?

Reflection question:

Assumption: You are in an environment where political correctness, “professional boundaries”, and the emotional and/or psychological vulnerability of the individual you are talking to are not an issue. Given this environment, you have the opportunity to ask a user of mental health services any question you want. What questions would you ask?

Program and organizational policies and procedures; the desire to be cost effective and efficient; respect for political correctness and professional boundaries; and the fear of liability can easily sidetrack helpers from remaining open-minded, patient and creative. Excessive implementation of rules, regulations, policies, procedures and documentation will readily distract service providers from the most important aspect of human service – seeing and connecting with the human being in front of them!

Refer back to you previous list and delete all the questions that are related to clinical assessment. What have you got left? What are you doing and asking to enable you to get to know the person? Effective helping relationships require trust? What can you do to develop a trusting relationship with people who come to you for help? What questions would you like to add to your list?

Disempowerment

Although the concepts of empowerment and recovery have been present in mental health for more than a decade, and many services, providers and others believe they are “doing it”, people continue to experience disempowerment at many levels in the systems, services, and programs available to them.

For example:

- “Schizophrenia and other serious psychiatric disabilities have been viewed as irreversible illnesses with increasing disability over time. Mental health program planning, policies, and practices have been implemented to support this uncompromisingly negative view of the predicted outcome for people with psychiatric disability. Spaniol, L. 2000 (see also Ridgway, P. 1998; Kruger, A. 2000)

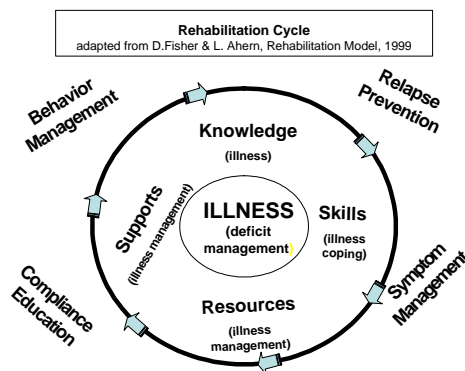
Programs and services based on this negative view of outcomes rob people of their future, trapping them in a continuous cycle of dependence, despair, and hopelessness.

While nominally applying a “strengths approach” to their service provision, some mental health services seem to focus on illness management, on controlling the person’s deficits and disabilities, rather than building a real life of pursuing hopes, dreams, goals, challenges, achievements and overcoming setbacks.

- “The rehabilitation view of recovery is that people can regain some social functioning, despite having symptoms, limitations, medication, and remaining mentally ill ... To say that the person’s mental illness is a permanent condition is to forever ostracize the person from society and say that they will never be able to regain a major social role.” D. Fisher (1999)
- “Many of us who have been psychiatrically labeled have received powerful messages from professionals who in effect tell us by virtue of our diagnosis our futures are already sealed.” P. Deegan (1995)

Dan Fisher, a psychiatrist and the co-director of the National Empowerment Center, and his colleague, co-director Laurie Ahern make this point with their illustration of the rehabilitation model. The Cycle of Rehabilitation is an adaptation of their model.

The Cycle of Rehabilitation



The cycle of rehabilitation is one of lifelong “illness”. No matter how far along the recovery journey the person has progressed; the cycle never allows the person to move beyond the “reality” of mental illness. Even when the rehabilitation focus is on the individual’s strengths, there is a danger of remaining stuck within the boundaries of the individual’s “negative realities”. The language used tends to reflect the “illness bias”; e.g. “potentials for higher functioning”; “increased self-sufficiency”; “improved standard of living”; “symptom reduction”.

For example: according to the International Association of Psychosocial Rehabilitation Services, the goal of psychiatric rehabilitation is to restore an individual's ability for independent living, socialization and effective life management. Psychiatric Rehabilitation services are designed to help an individual with a serious and persistent mental illness to:

- Develop coping strategies to **manage the symptoms of illness.**
- Develop behaviors and skills to **compensate for the functional deficits** in activities of daily living, interpersonal relations, problem relations, problem solving and cognition.
- Develop a supportive environment in which to **function independently as possible.**
- Build on personal strengths to **offset the effects of illness.**
- Coordinate all **treatment, rehabilitation, and support services.**
- **Manage crisis and relapses of the mental illness.**

Utilize community alternatives to psychiatric hospitalization when **clinically appropriate.**

Rehabilitation focused only on deficit management may fail to help the individual overcome the fear of strong emotions (anger is a symptom of illness; exuberance is a sign of mania; overwhelming grief and sadness is a sign of depression; fear is a sign of anxiety; etc.). Such rehabilitation may also fail to assist the person to understand their hallucinations and delusions, frequently leaving the individual in fear of these symptoms. Persons subjected to this rehabilitation process frequently learn to fear and manage their emotions, thoughts, and perceptions - to always question their interpretation of reality.

This cycle may interfere with the person healing completely, especially spiritually – for to heal spiritually requires a willingness to explore the unknowable, the unachievable, the unseen, the unspoken and unheard (Lunt, 2000). The risk of this rehabilitation cycle is to trap the person in a self-concept and self-efficacy based primarily on their ability or inability to manage their “illness”.

Another example of disempowerment is found in the situation where people are told that they cannot begin to recover until they “accept” their illness – until they “accept” the psychiatric interpretation of their reality. Recent literature calls this approach into question.

- “Acceptance of a disability may encourage people with a disability to succumb to the inferiority status that is often part of the disability stereotype.” Kravetz, Faust & David. 2000
- “...the acceptance of a psychiatric diagnosis label may reduce self-esteem, lower social status, increase a sense of ineffectiveness, and maintain a vicious cycle of behavioral and emotional disturbance.” Kirmayer & Corin, 1998

The issue of accepting illness will be addressed further in the discussion of recovery.

Many organizations, programs, and services insist that they follow the principles of empowerment, however the language and treatment approaches are incongruent with the principles of empowerment and recovery. All too frequently services and providers present themselves as the “expert”, exerting their “professional” credentials in a manner that exacerbates existing power differentials, meanwhile deluding themselves that they are facilitating empowerment and recovery.

Some programs and services have not only failed to shift to an empowering recovery paradigm – they have failed to keep up with the constantly evolving new understanding and visions of recovery. This failure to remain current with the latest research, best practices evidence, and recovery literature robs service users of options, opportunity, and their potential.

Many services and providers acknowledge that recovery involves the “whole” person; physical, mental, emotional and spiritual, yet fail to provide balanced, ‘holistic’ services and options. In particular, mental health service providers seem to be unable, afraid, and/or reluctant to assist people with the spiritual aspects of their struggles. Current recovery literature identifies spirituality as a key component of recovery for many individuals. The dearth of services sensitive to this aspect of recovery continues to disempower people.

Lack of services, barriers to access of services, abuse, rights violations, coercion, discrimination, stigma, poverty, unemployment, underemployment, unsafe housing, isolation, and social exclusion are among many issues that continue to plague people with mental illness.

Disempowerment has long been rampant in mental health. Beginning with the stigma associated with a psychiatric diagnosis, through to the attitudes of society, family, friends and helpers, people with mental health problems find themselves continually affronted by the barriers of discrimination. Over and over again they (people with mental health problems) find themselves blamed for the problems they did not invite into their lives. The greatest tragedy is the fact that many people self-stigmatize, further wounding their already crushed hopes, dreams, goals, self-esteem and spirit.

Describe a time when you felt disempowered. Have you experienced something entering your life and identifying you without your permission? How did you feel? How did you regain your power? How did you complicate your situation? What did other people do to help you empower yourself? How did they hinder you? How did you feel when you regained your sense of personal power? How can you apply the lessons of your experience to your work?

Empowerment

The word empowerment has become a popular expression in our culture and society. For example, our current federal government made extensive use of the word “empowerment” in a speech from the throne (late 1990’s). We hear the word used in many settings and situations – unfortunately, this has resulted in some misunderstanding of the meaning of empowerment.

Empowerment is a very complex concept and difficult to define. The purpose here is to examine the concept and principles as they apply to mental health.

“The concept of empowerment grew out of the consumer movement which protested against the shared feelings of disenfranchisement and powerlessness resulting from perceived abuse by service providers and human rights violations through involuntary commitment and forced treatment.” Ralph (2000)

First and foremost, empowerment is an issue of basic human rights. It is an issue of dignity, autonomy, responsibility, and self-determination.

Empowerment is also an issue of social justice and refers to the process that people go through to gain or regain the power and control over their own lives that is necessary for dignity and self-determination. It requires that people have access to the means and opportunity to assume responsibility for their own lives and well-being.

Empowerment is not a process of “receiving or being given authorization” to assume responsibility and control over some aspects of one’s personal life, but rather a process of personal choice, self-determination, and personal action.

The Cornell Empowerment Group (1989) defined empowerment as “an intentional, ongoing process centered in the local community, involving mutual respect, critical reflection, caring and group participation, through which people lacking an equal share of valued resources gain greater access to control over those resources (p.2).

Gutierrez (1990) defined empowerment as a process of increasing personal, interpersonal, or political power so that individuals can take action to improve their life situation.

Empowerment involves choosing to have a life in spite of having an illness and thereby moving toward recovery. It requires the belief that people can recover, help themselves and others, and define what they want and need. It is important that persons with schizophrenia, bipolar disorder, major depression, and all other psychiatric disorders understand and believe that they are not their illness. They are capable human beings who need and deserve dignity, love and happiness in their lives.

Empowerment is found in the deep-seated personal conviction, intention and ability to increase one’s sense of control and mastery of the problems and challenges with which one lives.

A measure of empowerment in mental health is found in a person’s opportunity and ability to express his or her opinions and feelings without having them judged as symptoms of mental illness. Empowerment is encouraged through the restoration of the dignity of risk and the right to failure.

Empowerment includes personal elements, social elements, and legal elements. Personal empowerment involves assuming responsibility for one’s own life in all its complexities, challenges, and potential. (Clay, 1990).

Social empowerment includes decent, affordable housing; meaningful jobs that pay decent wages; full participation in one’s community; and the support of family, friends and services which foster choice and growth. (Clay, 1990).

Legal empowerment includes the assurance of personal rights, such as the right to informed consent in treatment, to the least restrictive setting, to information about treatment, to participation in one's own treatment, and to assert grievances. (Clay, 1990)

Empowerment demands trust and respect before helping, rather than one-dimensional 'fixing', 'rescuing', 'directing', 'managing' and 'controlling'.

To be empowered ...

- is to know about the choices you can make and then make the right choice for yourself regardless of peer pressure or manipulation of any kind from anywhere.
- means to live a life that acknowledges guilt is an impediment to self-awareness and growth.
- means to live a life that is guided by clear visions of self that are healing and therefore you are always making the best decisions for yourself.
- is to make wise choices and put them into action. Having an abundance of knowledge is not empowerment if one cannot or will not put it into action.

Your decision and desire to be responsible for whatever happens as a result of your decisions and actions, presents a life of freedom because you are not overly influenced by external sources.

To facilitate someone's personal empowerment means...

- to reserve your judgments and personal opinions so as not to sway the person's decision.
- to not impose your expectations of them: to allow them expectations of themselves through the process of open relationships.
- to look at them with compassion, knowing they will and must have their own sense of self and their own experiences.

The person most likely to get well – to become empowered – is the person who feels free to question, to accept or reject treatment, and to communicate with and care for people who are caring for him... Ultimately, patient empowerment is a matter of self-determination; it occurs when a patient freely chooses his or her own path to recovery and well-being. It is the job of mental health services to provide an environment of personal respect, material support, and social justice that encourages the individual person in this process. *Clay (1990)*

We must assume responsibility for our destinies and ourselves in order to be empowered. And empowerment and reconnection are the core experiences of recovery. T DeRocher 1999

Empowerment is not something that can be given; it must be chosen and taken.

At the mental health service level, an empowerment paradigm requires that services and programs shift from a focus on symptom (problem) intervention, management, and maintenance to assisting people to achieve and/or maintain their chosen roles as equitable members of their community. Empowering programs assist people to define their issues and/or problems; identify their strengths, skills, knowledge, talents, dreams and goals; and utilize these attributes to define and achieve their own solutions and potential.

How does this concept of empowerment fit &/or challenge your understanding of your role as a mental health service provider?

What are you / your service or program doing well to facilitate this vision of empowerment?

What areas require improvement?

What does this improvement look like?

Recovery

Emerging in the mid 1980's, recovery from mental illness continues to evolve as a concept and reality. Over the past decade and a half recovery has been described from the perspective and understanding of consumers, clinicians, and family. Recovery has been described as a process; a vision; and as an outcome. The publication of first person recovery narratives in professional journals, consumer and family organization newsletters, newsmagazines, newspapers, and on the Internet provide us with a rich resource to gain more knowledge about this concept. Clinical research studies also provide us a wealth of information.

Despite the growing body of literature, and many excellent descriptions of recovery, a clear, concise, all-encompassing definition has yet to be offered. The best definition at this point may be from William Anthony of Boston University. (1993). He tells us:

Recovery is a deeply personal process of changing one's attitudes, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful life even with the limitations imposed by disability. It involves developing new meaning and purpose in life as one grows beyond the catastrophic effects of illness /injury.

In her presentation, "Recovery is a journey of the heart", (1996), Pat Deegan offers us a dynamic philosophical foundation on which to build our understanding of recovery. She states:

The concept of recovery is rooted in the simple and yet profound realization that people who have been diagnosed with mental illness are human beings... The goal is to become the unique, awesome, never to be repeated human being that we are called to be. Those of us who have been labeled with mental illness are not de facto excused from this fundamental task of becoming human. In fact, because many of us have experienced our lives and dreams shattered in the wake of mental illness, one of the most essential challenges that face us is to ask **who can I become** and **why should I say yes to life**.

These questions provide us with valuable clues to the task of undertaking the recovery journey and the support people require for this task. We will return to these questions later.

Other descriptions of recovery include:

Recovery is ...

- An evolutionary process – a process of growth and change – transformation that occurs at all levels: emotional, physical, mental, spiritual.
- Oriented to the achievement of health.
- Involves a process of redefining self – a positive identity that integrates the illness experience.
- Realization of the potential within and the potential for an alternate and preferable life.
- Redefining and reclaiming the right to dream and pursue one's passions.

The emotional experience of recovery is HOPE – a promise that things can and do change; that today is not the way that it always will be. Jacobson & Curtis, 2000

Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again. ...The need to meet the challenge of the disability and to re-establish a new and valued sense of Integrity and purpose within and beyond the limits of disability; the aspiration is to live, work, and love in a community in which one makes a difference. Deegan (1988)

Recovery is an ongoing process of growth, discovery, and change. (Stocks, 1995)

A recovery paradigm is each person's unique experience of their road to recovery. ...My recovery paradigm included my reconnection which included the following four ingredients: connection, safety, hope, and acknowledgement of my spiritual self. (Long, 1994)

To return renewed with an enriched perspective of the human condition is the major benefit of recovery. To return at peace, with yourself, your experience, your world, and your God, is the major joy of recovery. (Granger, 1994)

Recovery is a continuing, deeply personal, individual effort, and leads to growth, discovery, and the change of attitudes, values, goals, and perhaps roles (Anthony, 1993).

Recovery involves hope, courage, adaptation, coping, self-esteem, confidence, and a sense of control or free will (Blanch et al., 1993).

Recovery requires personal empowerment, and a spirituality/philosophy which gives meaning to life. (Beale & Lambric, 1994)

Recovery also includes constructive anger, advocacy for self and others, acceptance of personal responsibility, and asking for and receiving help. (Ralph, 1997)

Anthony, Deegan, and others also provide us with a variety of **recovery principles** including:

Professionals do not hold the key to recovery – consumers do. Recovery can occur without professional intervention.

Recovery is not about making flawed or defective people okay again.

A recovery vision is not a function of one's theory about the cause of mental illness.

Recovery can occur even though symptoms reoccur.

Recovery involves growth and setbacks, periods of rapid change and little change.

Recovery from mental illness does not mean that one was not really mentally ill.

Recovery from the consequences of illness is sometimes more difficult than recovery from the illness itself.

There are many paths to recovery – including choosing not to be involved in the mental health system.

Critical to recovery is regaining the belief that there are options from which to choose – a belief perhaps even more important than the particular option one initially chooses.

Accepting that one has an illness is not necessarily part of the recovery process. However, coming to an understanding of "what the problem is" in a way that allows one to take responsibility for one's behavior is necessary.

Recovery can mean that one is completely symptom free, uses no medication and no mental health services. (*recovery as an end point*)

Recovery can also mean that one is living a whole and healthy life with a psychiatric disability.

People require basic needs for safe, affordable housing, food, income, health care and opportunities to improve their lives in order to recover.

Disability does not exist inside of a person. External barriers (loss of social role, poverty, discrimination, lack of resources, oppressive assumptions and attitudes, etc.) are disabling. These must be removed to increase the likelihood of recovery.

Ahern & Fisher, in their PACE recovery guide list another set of principles:

People do fully recovery from even the most severe forms of “mental illness”.

“Mental Illness” is a label for severe emotional distress, which interrupts a person’s role in society, helps in a person’s recovery.

People can and do yearn to connect emotionally with others, especially when they are experiencing severe emotional distress.

Trust is a cornerstone of recovery.

People who believe in you help you recover.

People have to be able to follow their own dreams to recover.

Mistrust leads to increased control and coercion which interfere with recovery.

Self-determination is essential to recovery.

People recovering and those around them must believe they will recover.

Human dignity and respect are vital to recovery.

Everything we have learned about the importance of human connections applies equally to people labeled with “mental illness”.

Feeling emotionally safe in relationships is vital to expressing feelings, which aids in recovery.

Understanding the meaning within severe emotional distress helps with recovery.

Recovery has also been characterized and summarized as:

Recovery is a process, not an event.

Recovery does not mean cure.

Recovery is a deeply personal and unique experience.

Recovery is hard work.

Recovery involves the “whole person; it is a process of healing physically, emotionally, mentally and spiritually.

Recovering is a common human experience.

Recovery requires hope.

Recovery is the realization of the potential within us despite tragedy, disease and overwhelming darkness.

Spaniol, Koehler and Gagne (1999) describe recovery in terms of social outcomes. They say recovery is...

The ability to have friends and an intimate relationship.

To live in housing of one's choice.

To work in a job that fulfills one's skills, abilities (*and interests*).

To become a contributing member of one's community.

Models of recovery have also been presented offering insights into the phases and aspects of these processes. The time limitations of this workshop do not allow the exploration of these models in any depth but a quick look at the **Emotional Stages** of mental illness as outlined by Baxter and Diehl (1998) provides us with more useful information. (See appendix for further recovery models)

EVENT 1) Crisis: Psychosis, suicide attempt, Mania, Panic attack, etc.

Stage 1) Recuperation: A stage of dependence.

Emotions: Denial, confusion, despair, anger.

Needs: Safe Place, food, lots of sleep. Caregiver. Medications (probably).

EVENT 2) Decision: "Time to get going".

Stage 2) Rebuilding: Rebuilding independence.

Emotions: Grief, self-doubt, hope, anxiety, frustration, pride.

Needs: To be heard and accepted. Money, food clothes a good place to live.

Learning: About mental illness, people skills, work skills.

EVENT 3) Awakening: I am somebody. I have a Dream.

Stage 3) Recovery/discovery: building healthy interdependence.

Emotions: Acceptance of self and others, confidence, anger at injustice, helpfulness to others

Needs: A dream to strive for.

People who appreciate me.

Intimacy: someone to love.

Meaningful work.

Fun and physical activity.

To advocate for self and others.

Mary Ellen Copeland and Sherry Mead provide us with another perspective in their article, *What recovery means to us*. (2000) they describe the key facets of recovery as:

Hope

NO LIMITS - Limits crush hope; negative beliefs impact on the ability to move ahead.
“We don’t need dire predictions about the course of our symptoms – something which no one else, regardless of their credentials can ever know.” Mead, Copeland, 2000
People need assistance, encouragement & support – a caring environment without the feeling of being taken care of.

Personal Responsibility

Responsible for own wellness.
Change from victimhood (longing to be saved) to actively working at own healing and recovery.
Personal responsibility increases pace of recovery.

Education

What works for me?
What steps do I need to take?
What resources do I need?
Access to resources?
Understand and integrate this information.

Advocacy

Self advocacy is essential to rebuilding self esteem, sense of self efficacy.
Essential to getting what we want, need and deserve.
Essential counterpart to personal responsibility.

Mutual relationships and support

“Support holds few, if any, assumptions about people’s capabilities and limits. There is no categorizing and no hierarchical roles, with the result being that people move from focusing on themselves to trying out new behaviors with one another and ultimately committing to a larger process of building community.”
“Support, in a recovery based environment, is never a crutch or a situation in which one person defines or dictates the outcome. Mutual support is a process in which the people in the relationship strive to become fuller, richer human beings. SUPPORT WORKS BEST WHEN BOTH PEOPLE ARE WILLING TO GROW AND CHANGE.” Mead, Copeland, 2000

The National Association of State Mental Health Program Directors and the National Technical Assistance Center for State Mental Health Planning produced a report in October 2002 entitled, *Mental Health Recovery: What Helps and What Hinders?* This report provides excellent additional detailed information about recovery. The research results have been summarized in this workbook. The complete document can be found on the Partnership for Consumer Empowerment website at: <http://www.pccmanitoba.com/whathelps.pdf>

Additional recovery articles may also be found at: <http://www.pccmanitoba.com/resources.html>

Mental Health Recovery: What Helps and What Hinders? (Onken et al) 2002
(overview of Research Results)

To recover, people need:

1. Basic Material Resources

Hinders
Poverty
Unsafe and Unaffordable Housing
Lack of Transportation
Barriers to Benefits and Entitlements
Lack of Communication Services

Helps
Livable Income
Safe & Affordable Housing
Transportation
Information & Advocacy on Services & Benefits/Insurance Parity
Telephone Service
Resources from social networks

2. Personal Investment (Self/Whole Person)

Hinders
Negative Beliefs and Attitudes
Not Taking Personal Responsibility
Invalidation and a lack of information
A Lack of Discretionary Funds
Disabling Conditions / Health Problems
Labeling

Helps
Positive Traits and Attitudes
Self Reliance / Personal Resourcefulness / Dignity of Risk
Information and Education on Disorder
Self Advocacy and Self Determination
Self-Care / Self Monitoring of Symptoms
Seeing Self as Whole, Complete Person

3. Hope, Sense of Meaning and Purpose

Hinders
Dreams, Goals, Desires Demeaned, Devalued, Dismissed.
Poor Quality Services / Cutbacks
Pessimistic Staff
Spirituality Discounted or Ignored
Stigma, Prejudice, Discrimination
Sense of Hopelessness / Negative beliefs & Attitudes / Self-Stigma
Disabling Condition Itself

Helps
Developing a Sense of Meaning & Purpose / Having Goals.
Meaningful Service Choices
Staff are Hopeful / Realistic Optimism
Spirituality Acknowledged
Role Models, Friends and Peers
Positive Personal Attitudes / Hope, Optimism
Reclaiming & Appreciating Personal Strengths / Active Coping

Hinders
Unfulfilled Basic Needs
Lack of Education on Recovery Resources

Helps
Positive Personal Experiences / Housing & Sense of Home / Rejuvenation
Gaining Knowledge and Becoming Educated

4. Choice

Hinders
Limited or Lousy Options
Lack of Choices Regarding Basic Needs (finances, transportation, housing, socially segregated settings)
Unemployment & Underemployment
Lack of Meaningful Involvement in Treatment Planning / Lack of Right to refuse Treatment
Limited Treatment Options
Forced Treatment & Coercion
Family & Professional Control
Lack of Skills in Choice Making
Disabling Condition Itself
Stigma/ Discrimination/ Prejudice

Helps
Meaningful Options
Expansion of Choices regarding Basic Needs
More Job Choices
Educated on Treatment Options & Best Practices / Self Directed Planning / Advance Directives
Individualized Services & Treatment Planning/ Expanded Options/ Vouchers
The Freedom of Whether and How to Participate in Programs and Services
Self-Determination
Building Skills and Opportunities for Choice Making
Partner with Others in Recovery

5. Independence

Hinders
Paternalistic Orientation of the System/ Lack of Respect for Experiential Knowledge
Involuntary & Long-Term Hospitalization
Negative Attitudes & Beliefs (Fear, Lack of Confidence)
Risk & Fear of Losing Benefits/ Clinical Supports/ Safety Net
Stereotyping, Prejudice, Discrimination, Labeling

Helps
Making Own Choices and Decisions/ Increased Consumer Voice in System
Self-Determination/ Advanced Directives
Interdependence& Partnership
Having Affordable Housing, Car, Job, etc.
Basic Human and Civil Rights & Freedoms

6. Social Relationships

Hinders
Inadequate Social Network/ Social Isolation
Emotional Withdrawal/ Personal Isolation
Lack of Information for Families and Friends
Controlling Family Members
Lack of Social Skills
Stigma, Prejudice, Labeling, Negative Media Portrayals.
Disabling Conditions/ Health Problems
Social Status/ Immigrant Status
Trauma Experiences
Substance Abuse

Helps
Extended Networks/ Kinship Ties/ Friendships/ Affinity Groups (faith groups, tribes, etc)
Personal Ties (at least one person)/ Intimate Relationship
Openness to New Information, Strategies, Healing/ Advocates within Social Networks
Supportive & Accepting Kin
Communication/ Social contact (e.g. fun)/ Balancing Solitude and Social Togetherness
Volunteerism
Access to Means of Communication (i.e., phone service, Internet)
Social Choices
Mutual Aid/ Interdependence

7. Meaningful Activity

Hinders
Unemployment/ Role Loss/ Underemployment/ Limited Range of Jobs
Employment Disincentives in Benefits
Not Respecting Personal Decisions About Job Readiness or Interest
Lack of Training and Education Opportunities
Exploitation of Volunteer Work
Prejudice, Stigma and Discrimination/ Disclosure Fears

Helps
Choice Among Meaningful Employment Opportunities
Program and Policy Decision-Making
Respect Choices/ Readiness for Work
Educational Advancement (e.g. formal, self-directed)
Volunteer Work
Understanding & Respective Employers/ Accommodations
Advocacy Group Participation/ Systems Level Advocacy/ Community Organizing

8. Peer Support

Hinders
Lack of Funding / Infighting over Limited Funds
Peer Support not Available in Many Regions, especially Rural

Helps
Adequate Funding for Peer Support
Wide Availability of Peer Support Resources

Hinders
Limited Participation (e.g., same few people participate)
Limited Leadership Development Opportunities
Formal Service Provider and Staff Control/ Not Controlled by Members
Lack of Independent Peer Support Resources
Professional Mistrust of Peer Support
Lack of Transportation

Helps
Diverse Models of Peer Support (e.g., support groups, warm lines, case managers, etc.)
Role Models & Mentors
Exposure to Self-Help/ Self-Help Philosophy
Support Resources run by Consumers
Consumers employed within Traditional/ Formal MH Services
Accessing Other Self-Help Supports & Services (e.g., AA, NA)
Sharing Common Experiences

9. Formal Services

Hinders – Org. Culture & Structure
Culture and Organization that is Pathology –Focused/ Illness-Focused/ Dominance of Medical Model.
Lack of Change and Innovation
Lack of Holistic Orientation (e.g., neglect spirituality, physical health)
Access Limited to Those in Crisis
System Promotes Dependency/ Paternalism & Maternalism
Stigma Within the System
Social Segregation
Funding Problems
Lack of Consumer Voice on Personal and System Levels

Helps – Org. Culture & Structure
A Recovery-Oriented System with a Vision of Recovery/ Extending Support beyond Traditional Boundaries/ Consumer-Driven
Encourage Innovation/ De-Fund of Transform Ineffective Practice and Programs
Holistic Approach/ Proactive Approach supporting Preventative Measures/ Positive Mental Health
Multiple Strategies
Self-Responsibility/ Fostering Growth & Independence/ Assistance with Letting Go of Dependency on System
Fully Committed to Consumer Voice/ Support Risk Taking/ Freedom to Fail
More Tolerance for Diversity & Unusual Behavior
Adequate Funding and Equitable Distribution of Resources/ Monies Reinvested in Community/ Voucher System
Consumers Employed Within System at All Levels/ Consumers Involved in Decision – Making Processes Such as Staff Hiring & Firing/ Mandated Consumer Positions on Boards & Committees/ Office of Consumer Affairs/ Ombudsman Program

Hinders – Programs & Services
Coercion & Forced Treatment
Treatment/ Medication used as a means of Social Control
Debilitating Effects & Experiences of Long-Term Hospitalization
Substandard Services/ Poor Quality Assurance
Limited Access to Services & Supports/ Timelines, Time Limits
Fragmentation of Services, Eligibility Restrictions
Lack of Individualization
Lack of Needed Range of Services, Treatments and Options
Lack of Education for Consumers, Family Members and Community (e.g., illness, self-care, services, etc.)
Inadequate Continuity of Care

Helps – Programs & Services
Forced Treatment Avoided
Freedom of Whether or How to Participate in Services & Meds/ Self-Management of Medications
Inpatient Services as Last Resort but Available/ Small Scale/ Alternatives to Hospitalization/ Self-Directed Inpatient Care/ Advanced Directives Respected
Quality Clinical Care/ Consumer-Doctor Partnership/ Up-to-date Treatment Knowledge/ Clean & Modern Program Environments
No Waits/ Flexible
Coordinated Services Across Problems, Settings, & Systems/ Effective Case Managers with Low Caseloads & High Pay/ Disengagement or Reductions in Services Based on Consumers Self-Defined Needs
Tailored to Individual/ Wide Range of Choices as to Who Provides, What is Provided & Where Provided
Peer Support Services/ Therapy & Counseling/ Atypical Meds/ Family Services/ Employment Support & Career Development/ Respite Care/ Integrated Dual Diagnosis Services/ Jail Diversion and Community Reintegration Services/ Etc.
Patient Education, Illness Education/ Information on Meds, Effective Treatments & Services & How to Secure Rights/ Family Education/ Public Awareness Education/ (anti-stigma & pro-recovery)
System Navigators/ Extensive Outreach & Support (Multiple Languages, 24-7, Minority Focused)/ Homeless Outreach/ Safety Net Services
Access to Records/ Can Change Inaccurate Information
Early Intervention & Public Screenings/ Outreach to Churches, Schools, Communities.

10. Formal Services Staff

Hinders	Helps
Discontinuity/ Burnout/ Overworked	Continuity/ One-on-one Relationship/ Availability
Low Expectations/ Negative Messages	Hopeful/ Positive Expectations/ Belief that Recovery is Possible
Misunderstanding/ Mistrust	Understanding, Trustworthy/ Honest/ Open
Coercion/ Power-Over/ Formal Roles	Continuity/ One-on-one Relationship/ Availability
Paternalism/ No Understanding of Consumer's Experiences/ Superior/ Disrespectful	Listened to/ Believed/ Staff are Authentic, Respectful, Supportive, Caring, Responsive, Have Humility
Culturally Insensitive/ Devaluing/ Not Much Staff Diversity	Culturally Sensitive
Foster Dependency/ Discourage & Undermine Consumer Participation	Fosters Self-Empowerment
Inadequate Knowledge & Training (on trauma services, recovery process, effective meds & treatments, etc.)	Improved & On-going Training & education/ Consumers Involved as Trainers.

The possibility of recovery from mental illness can be understood as a vision, an outcome, and a process (Spaniol et al, 1999).

As a vision, recovery can define and shape the programs and services we provide in mental health because it is the goal and purpose of these programs and services.

Recovery outcomes are focused on the achievement of social measures such as intimate relationships; meaningful work; decent, safe, affordable housing; and full and equitable participation in one's community. Recovery outcomes also include the achievement of a sense of better health and a more positive sense of self.

Recovery as a process is often referred to in terms of transformation. It is the development of new meaning and purpose in life; the building of new attitudes, values, feelings goals, skills, and/or roles; and the pursuit of a satisfying and hopeful life (Anthony, 1993). Recovery is a complex, time-consuming process that can only be undertaken and achieved by the individual that chooses this path.

Individuals choose this path as they explore and answer the questions, who can I become; and why should I say yes to life. **(Adapted from Deegan (1996))**

Recovery Process Guiding Principles

- 1. Professionals do not hold the key to recovery – consumers do. Recovery can occur without professional intervention. The task of professionals is to facilitate recovery – the consumers' task is to recover.***

2. ***The consumer directs the recovery process; therefore, consumer input is essential throughout the process.***
3. ***The consumer's responsibility may include defining the "problem" and solution regardless of whether or not that includes acceptance of the psychiatric label.***
4. ***The mental health system must overcome its tendency to enable and encourage consumer dependency.***
5. ***Consumers are able to recover more quickly when their:***
 - a. ***Hope is encouraged, enhanced, and/or maintained.***
 - b. ***Life roles with respect to work, and meaningful activities are defined.***
 - c. ***Spirituality is considered.***
 - d. ***Culture is understood.***
 - e. ***Educational needs as well as those of their families/significant others are identified.***
 - f. ***Socialization needs are identified.***
6. ***Individual differences are considered and valued across their life span.***
7. ***Recovery from mental illness is most effective when a holistic approach is considered.***
8. ***In order to reflect current "best practices," there is a need to merge all intervention models, including Medical, Psychological, Social, and Recovery.***
9. ***Clinician's initial emphasis on "hope" and the ability to develop trusting relationships provides a positive influence on the consumer's recovery.***
10. ***Clinicians operate from a strengths/assets model.***
11. ***Recovery goals must be broader than the effective management of illness and related difficulties. The goals must focus on realizing the consumer's potential – to be who they are called to be.***
12. ***Clinicians and consumers collaboratively develop a recovery management plan. This plan focuses on the interventions that will facilitate recovery and the resources that will support the recovery process.***
13. ***Family involvement may enhance the recovery process. The consumer defines his/her family unit.***
14. ***Mental Health services are most effective when delivery is within the context of the consumer's community.***
15. ***Community involvement as defined by the consumer is important to the recovery process.***

(Sources: Deegan; Anthony; Ohio Mental Health Consumer Outcome Initiative Recovery Model Guiding Principles)

Summary of Recovery

Self empowering recovery is a personal reengagement with the process of life through ...

Reclaiming responsibility for one's own life.

The striving for better health (feeling better).

The experience of purpose, fulfillment, happiness and usefulness that everyone seeks.

The connection with one's dreams and passions.

The actualizing of one's inner potential.

Recovery requires that we make choices

Choose to believe that it is possible to "have a better life".

Choose to move beyond dissatisfaction with current life circumstances.

Choose to make a better life for oneself.

Choose to hope again.

Choose to believe we are more than the sum total of our diagnosis, problems, failures and dysfunctions.

Choose to believe that we have skills, talents, knowledge, and the ability to grow and change.

Choose to believe that we are capable human beings that deserve dignity, love, and happiness in our lives.

Choose to forgive.

Choose to be forgiven

Choose to believe that we need not live in fear of our thoughts, feelings and perceptions. To be truly alive is to experience the full range of emotions, thoughts and expressions.

Choose to believe that the process of growth and healing requires us to step forward and take risks. Failures and successes are an integral part of the human experience and are essential to learning.

Recovery requires Action

Develop an Action Plan

In developing my action plan, I can ask myself a variety of questions:

What are my problems, issues or concerns?

What do I want to change about my life now?

Given these challenges, what do I want to happen?

How can I accomplish what I want to happen?

What supports, resources, skills and knowledge do I need to make this happen?

Where and how do I access these supports, etc?

Take Action!

I believe successful recovery requires me to connect with my dreams and/or passions – regardless of how outrageous or unrealistic (delusional?) they may seem at the time. I need to explore them and then choose to pursue them, or revise and/or redefine them.

WHAT IS YOUR DREAM?

What are you doing to connect with your dreams?

*MY DREAMS CANNOT LIVE
BESIDE THOSE WHO WISH TO HOLD ONTO DOUBTS.*

*I CANNOT DREAM
WHERE PEOPLE ARE FOREVER PREOCCUPIED WITH "REALITY",
WITH HOW THINGS "ARE".*

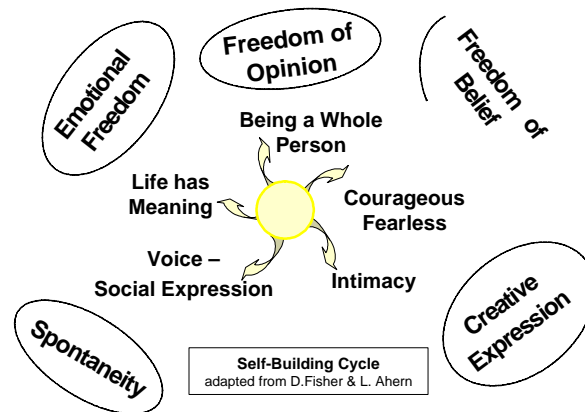
*I CANNOT HOPE
WHERE PEOPLE INSIST THAT WHAT I DESIRE CAN NEVER COME TO PASS,
WHERE MERELY DISCUSSING IT IS OFF BASE,
WHERE SEEING THINGS AS THEY ARE IS MORE IMPORTANT
THAN ENVISIONING HOW I WOULD LIKE THEM TO BECOME.*

*I REQUIRE THE FREEDOM AND SELF-DETERMINATION
TO PROCEED UNDER MY OWN POWER,
TO SUCCEED OR FAIL THROUGH MY OWN EFFORTS,
TO HAVE MY DREAMS AND VISIONS MEET THE UNCERTAINTY OF DAILY LIFE:*

THIS IS RECOVERY !

Adapted from Alan Lunt (2000;) used by permission

Finally we come to the self-building cycle. The self-building cycle is the cycle of life-perpetuating growth. It involves the person breaking free of the restrictions of fear, shame, guilt, societal prejudice and discrimination. The cycle liberates the person from mental illness. They are free of life-crushing, fear-based restrictions on thought, emotion, opinion, belief & the expression (behavior) thereof. The self-building cycle allows the person to experience a life of full participation in the richness of the human experience. (see: *Recovery: moving from a concept to a theory*. Alan Lunt (2000). *Psychiatric Rehabilitation Journal*, 23(4).



THE PROCESS OF RECOVERY IS ULTIMATELY BASED ON HOPE AND CHOICE. THE PRIMARY DRIVER OF THE PROCESS IS THE PERSON IN THE PROCESS THEMSELVES. THIS REALITY NECESSITATES FUNDAMENTAL SHIFTS IN HELPING STRATEGIES AND PRACTICES.

In your opinion:
How does the concept of recovery impact on your role as a helper?

What are the implications for your service/program?

What are you doing well?

What do you need to change?

What do you need to discontinue?

What are you missing?

In your opinion, what are the challenges in helping people answer the questions ***who can I become and why should I say yes to life?*** What are the benefits of this approach?

What strategies would assist you to improve your ability to help people with these questions?

What additional resources and/or information do you require to enable you and your service/program to effectively facilitate recovery?

Other comments or questions:

APPENDIX

Essential Components for Effective Community Services and Support:

1. Meaningful Relationships
2. Safe, Affordable, Decent Housing
3. Work/Meaningful Activity – Vocation
4. Community Participation
5. Empowerment
6. Accessible, Comprehensive Resources
7. Education
8. Recreation
9. Peer Support
10. Family Support
11. Elimination of Stigma, Discrimination, and Prejudice
12. Clinical Care

(ADAPTED FROM OHIO MENTAL HEALTH CONSUMER OUTCOMES INITIATIVE RECOVERY PROCESS MODEL)

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