THE RECOVERY VISION FOR MENTAL HEALTH SERVICES AND RESEARCH: A BRITISH PERSPECTIVE

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It may seem logical that if people can break down or become ill, then they can also overcome their problems and recover. Yet providers of mental health services often fail to emphasise such positive possibilities for people with mental health problems—particularly those with the most severe diagnoses. Psychiatric services often emphasize maintenance rather than recovery, and many survivors report that receiving a psychiatric label has been severely detrimental to their efforts to lead a worthwhile and enjoyable life and contribute to others.

In the last few decades, however, there are signs of greater appreciation for the potential of those considered to have a severe mental health problem. This has happened partly because of a burgeoning "consumer empowerment" movement in the UK, the US, and some other countries. People with "severe mental health problems" have formed influential local and national organizations, have become increasingly visible in conferences and committee rooms, are advocating for more empowering services, and are helping to shape both services and research.

In the US, the emergence of strong consumer organizations has been accompanied by growing discussion of a new vision: the vision of re-orienting both services and research toward recovery from severe or long-term mental illness (Anthony, 1991, 1993). During the 1990s, the implications of a recovery vision have been extensively debated by the various stakeholder groups. Indeed, the recovery vision has become so influential in the US that the Surgeon General (1999) in a landmark report on mental health has urged *all* mental health systems to adopt a recovery orientation.

Recently, the recovery vision has attracted considerable interest in Britain, too, where it has been adopted as the underlying principle for mental health services in the West Midlands. However, some consumer groups have expressed reservations about its relevance. In this paper, we assert that the recovery vision is as relevant to Britain as to the US in the effort to address mental health issues. This paper identifies some key themes about recovery, drawing on both US and British writers, explores the relevance of the concept in the British context, discusses concerns about the concept that have emerged in this country, and suggests a way for-

ward for Britain in exploring and benefiting from the recovery paradigm.

Origins and Definitions for the Recovery Concept

Some of the first writings in the US about recovery as a process were a number of published accounts of the first-hand experience of consumers/users/survivors (Anonymous, 1989; Deegan, 1988; Houghton, 1982; Leete, 1989; Lovejoy, 1984; McDermot, 1990; Unzicker, 1989). Such articles showed how some patients originally considered by mental health professionals to have a poor prognosis were overcoming many of their difficulties and discovering ways to live satisfying and contributing lives, despite some continuing problems. At the same time, it was also becoming apparent in the self-help and consumer movements that many people earlier considered to have "severe" and disabling mental illnesses were becoming leaders and examples for others.

A particularly moving account of a personal journey is that of Patricia Deegan (1988). She compares her own experience with that of a young disabled friend. Deegan was diagnosed in her late teens as schizophrenic, and her friend became paralyzed in an accident. Both were initially told that their condition was incurable and that they would be sick or disabled for the rest of their lives. Both experienced long periods of anguish, despair, and hopelessness. Yet through a process Deegan calls "recovery," both were able eventually to learn to manage their difficulties, and achieve meaningful goals. She became a psychologist; he became qualified to work with other disabled people. Despite some continued pain, struggle and disability, both took charge of their lives constructively, and, in that sense, "recovered."

Stimulated by such writings, the rehabilitation research and training center at Boston University has for some time been collaborating with various consumer/survivor leaders to develop the concept of recovery. By the early 1990s, the center's director, William Anthony, began urging that the idea of "facilitating recovery" be adopted as *"the guiding vision* for mental health services and research," on a par with preventing mental illness, and providing effective treatment and care (Anthony, 1991, 1993).

Anthony points out that recovery is a familiar idea in physical illness and disability. For example, it is not unusual to regard a person with paraplegia as having recovered, even though the spinal cord has not. Drawing on rehabilitation research and consumer literature, Anthony has spelled out the elements of a concept of recovery from mental health problems. This, he says, includes "the development of new meaning and purpose in one's life, as one grows beyond the catastrophic effects of mental illness (Anthony, 1993)." In a useful definition of recovery, he says:

> Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness.

He also notes that

> 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 what people with disabilities do. Treatment, case management, and rehabilitation are what helpers do to facilitate recovery.

Defining Themes About Recovery

Writings on the recovery vision have proliferated over the last decade – from accounts of personal experience, to professional analyses. Clearly, the process known as recovery varies greatly from one person to another, and does not follow any predictable sequence (Sullivan, 1994). Interpretations of key factors vary as well. From our perspective, however, there appear to be certain common themes that recur in much of the recovery literature.

Perhaps the single most powerful of these is *the importance of hope*. Many recovery stories describe the devastating effects of having been told by mental health professionals that prospects for recovery were slim or even non-existent. Many survivors report feeling overmedicated and/or trapped in the system as hopeless cases (Coleman, 1999). Those who feel they have recovered or are recovering, generally find ways to maintain, regain or create hope that somehow, someday, things will be better (Deegan, 1988).

In addition to hope, the following themes from the recovery literature are instructive for both service users and professionals in understanding what is involved at an individual level:

> *Being believed in and encouraged* by at least one other person who has confidence that progress and change are possible. This may be a loved one, a friend, a professional, or other users and survivors.
>
> *Developing perspective on the past,* and grieving over what has been lost, as part of preparing to move on.
>
> *Taking personal responsibility for one's life.* This involves the sometimes difficult task of taking charge of interactions with "the system,"

establishing relationships with empowering professionals and advocates, identifying preferred and unacceptable forms of treatment and services, and creating advance directives, where necessary. At a broader level, this includes learning about what triggers problems, developing successful coping strategies and building a lifestyle that supports wellness.

Acting to rebuild one's life, through taking small and sometimes bigger steps toward one's goals. These actions may require the overcoming of sometimes deep-seated fears, and may therefore involve an approach/avoid and a try/fail/try again dynamic that requires great courage (Perkins, 1999).

Developing valued relationships and roles. Building a support system, including family, peers, and other friends. Becoming "useful" and helpful to others, in whatever ways, rather than a perennial patient or client. This can often serve as a catalyst for improvements in confidence and self-esteem.

Changing other people's expectations of what one can achieve; regaining other people's confidence in one's ability and potential. This may involve resisting an identity dominated by an illness model.

Gradually gaining a sense of greater well being and contentment with life.

Developing new meaning and purpose in life, and where necessary, learning to accept personal limitations "as the ground from which spring [one's] own unique possibilities" (Deegan, 1988; Ridgeway, 2001). Related to this is developing a personal philosophy of life that is satisfactory and empowering. For many, this includes *finding and affirming the spiritual dimension* as a means of access to life's deeper meaning.

Persevering through pain, struggle, continuing or intermittent symptoms, setbacks, obstacles and other difficulties, recognizing that recovery is not a linear process, and that symptoms or relapses are more manageable within a stance of recovery.

An insight into various facets of the recovery process can have practical implications for consumers/survivors, family members, professionals, managers and policy makers alike. For example, particularly central to the recovery journey are gaining and maintaining hope, experiencing supportive relationships, and having valued roles and responsibilities. These recovery themes underscore the importance of "user involvement" and participation in mutual help or consumer organizations, which can often address aspects of the recovery process that elude professionals.

Recovery Related Resources and Research

The recovery vision emerged against a background of important psychiatric studies of the long-term outcome of schizophrenia (Harding, 1988; Harding, et al., 1992). These studies defined recovery as no current signs or symptoms of mental illness, no current psychiatric medication, and lack of vocational and social dysfunction. Yet, after an average of 32 years of follow-up, two thirds of a cohort of severely disabled, long-stay patients had significantly improved or recovered from psychiatric illness, despite what looked years before like very dim prospects. Those promoting the recovery vision can cite this as evidence that people with severe mental illness are much more likely to recover than was thought possible in the past.

Specific resources on the recovery vision have been developed in the US by Boston University's Center for Psychiatric Rehabilitation. A videotape presenting the overall concept is entitled *Toward a Vision of Recovery* (Anthony, 1994). Three books include: *The Experience of Recovery* (Spaniol and Koehler, 1994), a diverse and moving collection of personal stories, *The Recovery Workbook* and an accompanying *Leader's Guide* (both by Spaniol, Koehler and Hutchinson, 1994). The workbook is designed for self-study or to use with the *Leader's Guide* as material for consumer-led workshops or seminars to help people progress on their personal journeys toward recovery. The workbook offers a wide range of material to help people look at their individual situations in fresh ways, and there are also a variety of exercises to aid in thinking, feeling and/or perceiving the situation from fresh perspectives. These resources are valuable for anyone wishing to apply or develop the recovery concept.

Work by other organizations on the recovery concept has been described in two special issues on recovery of the *Community Support Network News* (Center for Psychiatric Rehabilitation (1991, 1998) and in numerous articles of the *Psychiatric Rehabilitation Journal*. Work on the wider subject of hope in all kinds of enterprises has been pursued through the Center for a Science of Hope in New York City, and the Hope Foundation in Alberta, Canada, which have offered conceptual and research perspectives.

Recovery Related Thinking and Resources in Britain

Long before the concept of recovery began being promoted as a unifying vision, recovery ideas and ideals were reflected in Britain in the literature of mutual and self-help organizations. For example, the mutual help organization

called GROW (adapted from AA's 12 steps, and developed mainly in countries *other* than the UK) is based on some of the same ideas as the recovery movement. Similar ideas are reflected in the philosophy and experience of British mutual help organizations including the Self-Harm Network, Depression Alliance, Manic Depression Fellowship and the Hearing Voices Network.

Until recently, however, at a national level, British mental health literature and research has talked about "self-management" of problems and "coping strategies," or "strategies for living" rather than about recovery, per se. For example, a series of publications from the Mental Health Foundation's (MHF) Strategies for Living project are highly relevant to recovery issues but do not use recovery language (1997, 1998, 2000a, 2000b, 2001). These reports resulted from several years of research led by mental health service users.

The first report, *"Knowing Our Own Minds,"* was a survey of how people in emotional distress take control of their lives (MHF 1997). The report emphasized the importance of taking responsibility for one's own health, learning to manage one's symptoms, and getting support from other people. Another issue was "finding ways to motivate one's self" to take positive action. The report found that among the forms of help and treatment most valued or sought by service users were talking treatments, complementary therapies, and spiritual or religious support.

A second report, *"Healing Minds"* (Wallcraft, 1998), followed up the interest in complementary therapies, and found evidence that mental health service users in Britain were benefiting from a wide range of therapies including acupuncture, homeopathy, massage, aromatherapy, reflexology, nutritional therapies, exercise and yoga. The types of benefits reported included: relief of stress, anxiety and depression; reduction in side effects of medication; ability to reduce medication; increased hope; increased well-being; and increased sense of control over one's life.

A third report, *"Strategies for Living,"* (MHF2000a), identified a range of personal coping strategies. Positive, accepting and supportive relationships were found to be the most important single factor in coping. Another key finding was the diversity and wide range of individual coping strategies that people developed. This led to the conclusion that mental health services need to take a more holistic approach to supporting personal coping strategies, recognizing expertise based on personal experience.

The research on strategies for living also led to a conference, reported under the title *"The Courage to Bare Our Souls"* (MHF 2000b). The report speaks of "the sometimes profound effects of a belief or faith on people's lives...on the whole person, mental, physical and spiritual." This theme appears independently in many personal accounts of recovery.

In a recent book of stories on overcoming mental distress (MHF 2001) from the same project, people talk of their strategies for survival, and for managing, or conquering distress, using techniques of self-help, learning from each other, and rising above a painful and abusive past to become strong and proud of themselves. As one person put it, "I started to see my so-called 'symptoms' as a reasonable response to many of the things that had happened to me in the past" (p.25). People describe techniques of mutual support, self-expression through writing, talking and creativity, complementary therapies and prayer.

Recovery Specific Thinking and Development in Britain

In recent years, the recovery concept has attracted the attention of growing numbers of mental health reformers in Britain, some of whom see it as a next step in developing from the work on strategies for living. Others see the recovery vision as radically challenging the medical paradigm of life-long illness, disability, and dependence on services.

A strong and articulate British advocate for the recovery vision and role model for the recovery process is Dr. Rachel Perkins. Self-proclaimed as having "ongoing mental health problems," she works as a clinical psychologist and director of a rehabilitation and continuing care service. She says that the recovery vision "provided [her] with a way of synthesising [her] personal and professional selves." She also likes the way recovery

> shifts the focus on what services must do to the uniquely personal and individual journey that the disabled individual faces, and the ways in which services and professionals may help or hinder this process (Perkins, 1999).

Perkins believes that the recovery concept helps resolve the constant tension in psychiatric rehabilitation between "negativity" and "realism." Although recovery literature repeatedly emphasizes the importance of hope, it also shows that realism, in terms of an acceptance of some degree of impairment, is an essential ingredient. In these and other ways, she notes that recovery ideas "redefine the ball park, providing a completely different way of thinking from ideas of 'treatment' and 'cure'" (1999).

Recovery has recently become a topic for survivor literature in Britain as well. Three key publications include:

Recovery: A Holistic Approach (Reeves, 1999), *Recovery, An Alien Concept* (Coleman, 1999), and the recovery workbook *Victim to Victor: Working Towards Recovery* (Coleman, Baker and Taylor, 2000). Reeves describes recovery as finding one's balance, through a holistic approach to life, and as a journey of self-discovery and growth. Coleman (1999) argues that clinical notions of recovery are based on language that meets the needs of professionals, but not users, and suggests that the use of "outcome measures" is a way to disguise the failure of psychiatric treatments to promote genuine, user-defined recovery.

The recovery vision has also informed a useful series of "directional papers" on developing modern community mental health services published by an International Mental Health Network (Carling & Allott, 1999; Carling, Allott, Smith, & Coleman, 1999). The authors are working with mental health leaders in the US, Britain, Italy and elsewhere to encourage and assist with service improvements based on the recovery vision and related concepts. This group hopes to develop an international center based in Britain to promote recovery ideas.

The Mental Health Foundation also took up the recovery vision as part of its SPIRAL program. The acronym stands for "supporting prevention, early intervention, recovery, and learning." The importance of sharing personal stories of recovery was one of the key messages to emerge from this work. Telling one's story has long been acknowledged as a means to uncover pain, discover resources, share experiences and recover from distress. Gersie (1997) writes about "therapeutic story making," a system designed specifically for people with mental health problems. She describes self narratives as the way in which we create meaning in our lives, understand, and learn from the past.

Issues Raised in Britain About the Recovery Concept

In Britain, discussions of the recovery concept have been linked to wider discourses challenging the prevailing scientific paradigms in medicine. For example, Bracken and Thomas, 2000; Michaelson & Wallcraft, 1997; Crane, 1998; Plumb, 1999; and Barker, 2000 have all written about the need for a new paradigm, without having explicitly considered the work on recovery in their discussions. Coleman (1999) also argues that it is necessary to "deconstruct" the discourse of psychopathology in order to "find hope for the implementation of a recovery-driven psychiatric system" (p.70).

However, some mental health service users in Britain have questions and reservations about the concept of recovery. The Mental Health Foundation's brainstorming day on recovery raised the following issues:

- *Recovery from what?* Does speaking of "recovery" imply acceptance of a medical approach to mental illness; i.e., if you don't see yourself as "ill" in the first place, how can you recover?
- *Recovery to what?* The "recovery movement" feels to some people rather like a "born-again" revival that they don't want to join. Will those who do not recover be regarded as failures by other "recovered" survivors? Will those who "recover" have support and benefits prematurely withdrawn?
- *Whose recovery is it anyway?* Will "recovery" be adopted as fashionable jargon by mental health professionals and used to judge service users in a way similar to the current use of "compliance"? (e.g., will service users who don't progress through a series of recovery hoops be seen as uncooperative and be penalized in some ways?). Also, could a focus on recovery contribute to neglect of those considered less able or willing to recover?
- *Why import recovery language?* Some think it would be better to continue building on indigenous concepts such as "strategies for living" and others, rather than encourage re-thinking through use of the recovery vision.

Concerning the first issue, *recovery from what?*, the international literature of recovery shows that while a few first-hand accounts implicitly accept an illness paradigm, more are *neutral about causation*. And many recovery articles criticize an over-reliance on the medical model (see, for example, California Alliance for the Mentally Ill, 1994). *The Recovery Workbook* (Spaniol, Kohler and Hutchinson, 1994), provides useful distinctions between impairment, a dysfunction, a disability, and a disadvantage, and in this way offers more precise concepts for analyzing one's own situation. It also suggests ways of defining "stress-related issues/problems" as "information, skill or support deficits," rather than as something that is wrong with us. Having defined one's problems in this way, it is then easier to set precise and practical personal goals.

In the international literature, accepting that one has an illness is *not* generally seen as a necessary part of the recovery process; however, it generally *is* seen as necessary to come to an understanding of what the problems are. A pragmatic view of causation is taken by Perkins (1999) who writes: "Whether mental health problems are viewed in biological, social, psychological or spiritual terms, recovery is still a necessary process."

Whatever their theory of causation, many recovery writers emphasize adverse effects of “the system” or of treatment itself (Unzicker, 1989). Perkins (1999), for example, emphasizes how “living with the discrimination and exclusion that accompany madness, and the gulf between ‘us and them’....and having whatever you say dismissed as a symptom of your madness,...can be a great deal more difficult than living with the mental health problems themselves.”

Indeed, overcoming the iatrogenic effects of mental health treatment, and coping with stigma and exclusion, are generally accepted as necessary parts of the recovery process. At the same time, such issues continue to highlight the need for public education, social change, and changes in professional attitudes and practices.

In evaluating the relevance of the recovery concept to mental health, we also believe some of the wider, commonsense meanings of the term are useful. In general conversation, recovery describes an individual process of overcoming a wide range of personal adversities, which may or may not be related to an illness. To cite just a few examples, one may recover from bereavement, a business or career failure, a relationship disappointment or a failure to pass an important examination. So it is possible to accept the value of a recovery vision without getting bogged down in sometimes sterile and polarizing debates about the medical model.

A slightly different and very useful perspective on recovery language has been expressed by Liebrich (1999), who edited a book of positive stories about surviving mental illness by people in New Zealand. She says:

> As I listened to people, I began to struggle with the word “recovery.” Some people in the book were quite comfortable with the word, and talked about stages of recovery. Others didn’t want to use the word, because it can imply a simple and finite solution....I am so struck by the complexity of the process of getting well. As people talked about dealing with illness, their stories were about the progressive discovery of solutions.
>
> At the same time, something else emerged....people talked about the discoveries they had made about themselves....I have often felt that dealing with my own illness has given me something beyond recovery, something more than recovery. And now I heard others say the same. This was a precious insight.
>
> If there were one word I would choose to describe what I heard throughout this work, it would be DISCOVERY (Liebrich, 1999, p. 181).

The second issue, *recovery to what* needs more discussion amongst survivor groups and others, as does the question of whether use of recovery language and emphasis on the recovery vision could be divisive and alienating for those who don’t spontaneously “take to it.” Is there a danger that an overemphasis on recovery could be an additional burden for people who do not feel they are in “recovery,” whereas language such as surviving, coping, or developing strategies for living is more neutral and accepting? On the other hand, some find the concept of recovery inspiring and liberating, offering the prospect of going beyond simply “coping with distress.”

A related concern is the fear that the recovery paradigm could be used as a rationale for withdrawing needed benefits or services. There are good reasons for people to fear that they will be discriminated against in the job market and that they may lose more than they gain by abandoning the “sick” role. Governments need to address this issue if the concept of recovery is to make real headway. Equally important is the question of whether a focus on a recovery paradigm could provide a rationale for increased attention toward the more rewarding clients, to the detriment of those in greatest need. These are complex issues that require discussion amongst all the stakeholder groups, including those responsible for formulating relevant social policies.

Concerning the third issue, *whose recovery is it anyway?*, it must be acknowledged that there are dangers to use of the recovery concept if professionals rather than service users define its meaning. Coleman (1999) warns that too often professionals view recovery as little more than maintaining the patient in a “stable condition, regardless of issues such as adverse affects [sic] of medication or even the expressed wishes of the client.” He also argues against defining recovery in terms of professional outcome measures such as symptom rating scales and even quality of life scales, which may mean little to clients and fail to reflect the subjective personal experience of recovery. This issue can best be addressed by ensuring full involvement of service users at a grassroots level in developing the use of the recovery approach in Britain, rather than trying to impose the concept from the top down.

Concerning the fourth issue, *why import recovery language?*, it seems clear that the recovery vision has *already* found its way into the international mental health literature, and has gained momentum in Britain as well as other countries. Clearly, the concept has proven to be a dynamic and creative one for many. The challenge is for British mental health reformers to explore the recovery paradigm and use it to enrich thinking, policy and practice in this country.

Potential for Further Development of the Recovery Vision in Britain

Conditions in Britain for understanding and applying a recovery-oriented approach to services and research are excellent. In recent years, many people here have found useful, contributing roles through the survivor movement—making their way towards recovery, in terms of a more fulfilled and satisfying life, whether or not recovery language was used. Many professionals in Britain are working collaboratively with service users, both in planning and service delivery. For example, survivor researchers are now working in organizations such as the Mental Health Foundation, the Sainsbury Centre for Mental Health, and the Institute of Psychiatry. Some local service providers such as the Pathfinder Trust are recruiting mental health service users as service workers. The networks and leaders who can evaluate and develop the recovery vision are in place.

As noted, Britain also has a number of mutual help organizations whose work is relevant to the recovery vision. For example, the Self-Harm Network, the Manic Depression Fellowship, and the Depression Alliance offer hope and support for self-management or recovery. The Hearing Voices Network offers alternative non-medical explanations and solutions to voice hearers. The mutual help organization known as GROW (which has a large number of groups in the US, Australia and Ireland), also exists in the UK in rudimentary form, and offers the possibility of systematically establishing and nurturing a network of local mutual help groups that promote recovery (Rappaport, 1985).

Facilitating recovery of people who have traditionally been excluded from full citizenship because of their mental illness label is highly relevant to the British government's theme of promoting social inclusion. In 1999, MIND's inquiry into social exclusion found that a psychiatric diagnosis is often the start of social exclusion rather than leading to a therapeutic or supportive process. They found that NHS psychiatric services and general health care services themselves might add to the problem by stigmatization and ghettoization. Promotion of a recovery-oriented vision of mental health may be one way of addressing such issues.

The recovery vision is also relevant to the Government's *National Service Framework for Mental Health* (1999). For example, the framework emphasizes "preventing suicide and providing effective services" for people with severe mental illness. A focus on recovery and the related interest in "hope inspiring strategies" is clearly relevant to suicide prevention. In addition, the recovery vision can inform understandings about service "effectiveness." For example, the recovery vision suggests that in additional to usual measures of effectiveness, attention should also be given to such issues as assuring or maintaining role functioning, participating in fulfilling self development activities, and empowerment (Anthony, 1993). MIND has already urged that the government adopt performance indicators that reflect issues of life quality that have been shown to be important to service users, rather than relying solely on clinical issues such as symptom reduction, (Dunns, 1999).

Next Steps

In addition to discussing how to *manage* mental health problems, we believe the time has come in Britain to consider how best to *overcome* such problems. But what steps should be taken in Britain to draw out the useful aspects of the recovery paradigm and use it to enrich policy, services and research? We think some of the following would be appropriate:

First, the international literature of recovery should be made widely available, since this can inform and inspire users/survivors, families, professionals and policy makers alike. The recovery approach offers fresh ways of viewing one's situation, and clearly the choice of how to view one's predicament is fundamental to empowerment and freedom.

Second, people interested in the recovery approach can try out application of recovery ideas through self or group study of a recovery work book (e.g. Spaniol, Koehler, & Hutchinson, 1994, or Coleman, Baker, & Taylor, 2000). It would be particularly useful in Britain to organize user-led seminars or workshops using available American and British materials. This would build up experience with recovery thinking at grassroots level. Feedback from such seminars could contribute to further development of resource materials geared specifically toward a British audience.

Third, the various mental health stakeholder groups should examine the recovery vision and its implications, learning from individual recovery stories, and exploring how policies and services help or hinder the recovery process.

Fourth, service users who wish for continuing support for recovery should be given opportunities to join or establish ongoing local survivor or mutual help groups, where they can support and learn from one another. Where local groups don't exist, GPs, psychiatrists, counsellors and managers can identify potential group leaders, offer resource materials, and facilitate links with health and social service organizations that may offer guidance and support. Local demonstration projects to implement and evaluate the GROW model could

also be instructive as a way of developing infrastructures that promote recovery.

Fifth, new resource material on recovery should be developed specifically for use in Britain, building on international work and on findings of various user-led projects. These materials should include collections of recovery stories, which could be produced through facilitated story telling (Gersie, 1997; White & Epston, 1990). Resource materials on steps to recovery or on organizing local recovery groups could also be useful, drawing on experiences of recovery workshops in Britain.

Conclusion

We believe that the recovery vision offers a dynamic, creative new way of looking at mental health issues - a way that is as relevant to Britain as to any other country. The challenge to all stakeholder groups is to get to grips with this new vision, and draw out its many positive implications. We also believe that the recovery vision can offer useful contributions to the wider international debate on re-framing mental health services (Bracken & Thomas, 2000; Michaelson & Wallcraft, 1997; Crane, 1998; Plumb, 1999; and Barker, 2000).

Nonetheless, for reasons implicit in this paper, we believe that discussions of the recovery vision should be accompanied by continued attention to other vital and *complementary themes*. These include, for example: prevention; early intervention; *user* involvement; practical measures for social inclusion; strategies for living, surviving and coping; and the generating and maintaining of that vital ingredient – HOPE.

At the same time, we urge British service users and mental health reformers to seize the opportunities presented by the recovery vision. We hope the coming years will bring focused discussion and development of the concept at local and national levels, development and dissemination of personal stories of surviving and recovering, and extensive learning about what helps and hinders the journey toward recovery.

As those who are surviving, coping and/or recovering share their stories; as we deepen our understanding of what is involved; as we evaluate services to determine their relevance for recovery; as opportunities are increased for social inclusion and socially valued roles, it will become more and more possible to demonstrate that in the future becoming or being seen as "mentally ill" need not be the end of the story.

References

Anonymous (1989). How I've managed chronic mental illness. *Schizophrenia Bulletin, 15,* 635–640.

Anthony, W. (1991). Recovery from Mental Illness: The new vision of service researchers. *Innovations and Research, (1)*1, 13–14, December.

Anthony, W. (1993). Recovery from Mental Illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, (16)*4, 11–23, April.

Anthony, W. (1993). Recovery from Mental Illness: The guiding vision of the mental health service system. *Innovations and Research, (2)*3, 17–25.

Anthony, W. (1994). The recovery vision. *The Journal of the California Alliance for the Mentally Ill, (3)*3, 5. 1111 Howe Avenue, Suite 475, Sacramento, CA.

Anthony, W., Cohen, M., & Cohen, B. (1994). Philosophy, treatment, process and principles of the psychiatric rehabilitation approach in Bachrach (Ed.), *New Directions for Mental Health Services: Deinstitutionalization, 17,* San Francisco, Jossey-Bass.

Anthony, W., Cohen, M., & Farkas, M. (1990). *Psychiatric Rehabilitation.* Center for Psychiatric Rehabilitation, Boston, MA.

Barker, P. (2000). The Tidal Model: A Holistic Approach to Psychiatric and Mental Health Nursing (unpublished manual).

Bracken, P., & Thomas, P. (2000). Prison wardens or mental health professionals?, *Openmind, 101,* 20. Jan/Feb.

California Alliance for the Mentally Ill. *The Journal. Special Issue on Recovery, (5)*3. 1111 Howe Ave, Suite 475, Sacramento, CA, 95825. ($25 per special issue).

Carling, P., & Allot, P. (1999). *Core Vision and Values for Mental Health: Directional paper 1 on developing modern community mental health systems.* International Mental Health Network, West Midlands Partnership for Mental Health.

Carling, P., & Allott, P (1999). *Beyond Mental Health Services: Integrating Resources and Supports in the Local Community. Directional paper 2,* International Mental Health Network, for the West Midlands Partnership for Mental Health.

Carling, P., Allott, P., Smith, M., & Coleman, R. (1999). *Helping to Articulate the Direction of the Mental Health System of the Future: Directional paper 3: Principles of Recovery,* International Mental Health Network, for the West Midlands Partnership for Mental Health.

Center for Psychiatric Rehabilitation, Boston University (1991). *Community Support Network News, Special issue on recovery, (8)*1. 940 Commonwealth Avenue West, Boston, MA, 02215.

Center for Psychiatric Rehabilitation, Boston University (1998). *Community Support Network News, Special issue on recovery, (13)*1. .

Center for Psychiatric Rehabilitation, Boston University. *Toward a Vision of Recovery for Mental Health and Psychiatric Rehabilitation Services.* 30-minute video with booklet of readings on recovery by W. Anthony. 940 Commonwealth Avenue West, Boston, MA, 02295. ($85 plus shipping)

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Chamberlin, J. (1998). *On our own,* London, MIND.

Chamberlin, J. (1990). The expatients' movement: Where we've been and where we're going. *The Journal of Mind and Behaviour, (11)*3, 323–336.

Coleman, R. (1999). *Recovery: An alien concept,* Handsell Publishing, Gloucester.

Coleman, R., Baker, P., & Taylor, K. (2000). *Victim to Victor: Working towards recovery,* Handsell Publishing, Gloucester.

Craine, S. (1998). Shrink resistant: The Survivor Movement and the survivor perspective, *US Network Working Papers 3,* Exchange and Change.

Davidson, L., & Straus, J. (1992). Sense of self in recovery from severe mental illness. *British Journal of Psychiatry, 65,* 131–145.

Deegan, P. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, (11)*4, 11–19.

Deegan, P. (1990). Spirit breaking: When the helping professionals hurt. *The Humanistic Psychologist, (19)*3, 301–315.

Dunns, S. (1999). *Creating accepting communities.* London, MIND.

Department of Health (1999). *A National Service Framework for Mental Health,* London.

Esteroff, S. (1994). Keeping things complicated: Undiscovered countries and the lives of persons with serious mental illness. *The Journal, (3)*3, 40–46. California Alliance for the Mentally Ill.

Farkas, M., Gagne, M., & Anthony, W. *Recovery and rehabilitation: A paradigm for the new millennium.* Center for Psychiatric Rehabilitation, Boston University, Boston MA, unpublished, no date.

Fischer, D. (1996). *Recovery is for everyone.* Video, National Empowerment Center, Lawrence, MA.

Fischer, D. (1994). Hope, humanity and voice in recovery from psychiatric disability. *The Journal, (3)*3, 13. California Alliance for the Mentally Ill.

Gersie, A. (1997). *Reflections on Therapeutic Storymaking: The use of stories in groups,* London: Jessica Kingsley.

Harding, C. (1986). Speculations on the measurement of recovery from severe psychiatric disorder and the human condition. *Psychiatric Journal of the University of Ottawa, (1)*14, 119–203.

Harding, C. (1998). Course types in schizophrenia: An analysis of European and American studies. *Schizophrenia Bulletin, 14,* 633–643.

Harding, C., & Zahniser, F. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatr Scand, 90,* (suppl. 384), 140–146.

Harding, C., Zubin, J., & Strauss, J. (1992). Chronicity in schizophrenia: Revisited. *British Journal of Psychiatry, (161)*18, 27–37.

Hatfield, A. (1994). Recovery from mental illness. *The Journal.* California Alliance for the Mentally Ill, *(3)*3, 6–7.

Hope Foundation. 11032-89 Avenue, Edmonton, Alberta, Canada T6G976, tel. 403-492-1222, fax 401/492-9813.

Houghton, J. (1982). Maintaining mental health in a turbulent world. *Schizophrenia Bulletin, 8,* 548–552.

Hutchinson, D., & Skrinar, G. Exercise and self-esteem: The Implications for persons with severe mental illness. *Medicine and Science in Sports and Exercise, (26)*5, S76.

Jungheim, C. (1994). Recovery, Inc.: A method of will training. *The Journal, (5)*3, 47–48. California Alliance for the Mentally Ill.

Kirkpatrick, H., Landeen, J., Bryne, C., Woodside, H., Patrick, J., & Bernardo, A. (1995). Hope and Schizophrenia: Clinicians identify hopeful strategies. *Journal of Psychosocial Nursing, 33*(6), l5–19.

Koehler, M. (1994). Values and Love in Recovery: Is there life after coping? *Innovations and Research, (3)*2.

Leete, E. (1988). The treatment of schizophrenia: A patient's perspective. *Hospital and Community Psychiatry, (38)*5, 486–491.

Leete, E. (1989). How I perceive and manage my illness. *Schizophrenia Bulletin, 15*(2), 197–200.

Leete, E. (1994). Stressor, symptom, or sequelae? Remission, recovery, or cure? *The Journal, (5)*3, 16–17.California Alliance for the Mentally Ill.

Lieberman, R., & Kopelowicz, A. (1994). Recovery from schizophrenia: Is the time right? *The Journal, (3)*3, 67–69. California Alliance for the Mentally Ill.

Lieblich, A., Turval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis and interpretation.* Thousand Oaks, CA: Sage.

Liebrich, J. (1999). *A gift of stories: Discovering how to deal with mental illness.* University of Otago Press/Mental Health Commission, Dunedin New Zealand.

Lovejoy, M. (1982). Expectations and the recovery process. *Schizophrenia Bulletin, (8)*4, 605–619.

Lovejoy, M. (1984). Recovery from schizophrenia: A personal odyssey. *Hospital and Community Psychiatry, 35*(6), 809–812.

May, R. (in press). *Routes to recovery from psychosis: The roots of a clinical psychologist.* Clinical Psychology Forum.

Mental Health Foundation. *Knowing our own minds: A survey of how people in emotional distress take control of their lives.* London, 1997.

Mental Health Foundation (1999). *The courage to bare our souls,* London.

Mental Health Foundation (2000). *Strategies for living: A report of user-led research into people's strategies for living with mental distress,* London.

Mental Health Foundation (2001). *Something inside so strong: Strategies for surviving mental distress.* London: Mental Health Foundation.

Michaelson, J., & Wallcraft, J. (1997). Alternatives to the biomedical model of mental health crisis. *Breakthrough, (1)*3.

Moxley, D. Serious mental illness and the concept of recovery: Implications for social work practice in psychiatric rehabilitation. *Psychiatric Rehabilitation and Community Support Monographs, (2)*2. Boston, MA: Center for Psychiatric Rehabilitation.

Perkins, R. (1999). Recovery models. Presentation to the Bromley Psychosocial Rehabilitation Forum.

Perkins, R. (1999). *Psychosocial News, (2)*1. Bromley Psychosocial Rehabilitation Forum.

Perkins, R. (1999). Presentation to Rehabilitation in the Community Conference, Birmingham, May.

Perkins, R. (1999). The Individual's Journey: Recovery and Service Provision. Presentation to Good Practices in Community Nursing Conference, Manchester.

Plante, T., & Rodin, J. (1990). Physical fitness and enhanced psychological health. *Current Psychology Research and Reviews, 9,* 1–22.

Plumb, A. (1999). New mental health legislation. A lifesaver? Changing paradigm and practice, *Social Work Education, (18)*4, 459–478.

Ragin, M. (1994). Recovery: Changing from a medical model to a psychosocial rehabilitation model. *The Journal, (5)*3. California Alliance for the Mentally Ill.

Reeve, A. (1999). *Recovery: A holistic approach.* Handsell Publishing, City Works, Gloucester.

Ridgway, P. (2001). ReStorying psychiatric disability: Learning from first person recovery narratives, *Psychiatric Rehabilitation Journal, 24*(4), 335–343.

Russinova, V. (1989). Promoting recovery from serious mental illness through hope-inspiring strategies. *Community Support Network News, (13)*1, 1, 4–6. Boston, MA: Center for Psychiatric Rehabilitation.

Skrinar, D., & Hutchinson, M. Psychiatric disorders and exercise. Draft article for the *Encyclopaedia of Sports Medicine and Exercise Physiology,* Boston University Department of Health Sciences. No Date.

Spaniol, L., Koehler, M., & Hutchinson, D. (1994). *The experience of recovery: Self reports by people with mental illness.* Center for Psychiatric Rehabilitation, Boston University, Boston, MA.

Spaniol, L. The family recovery process. *The Journal, (3)*3, 57–58, 19. California Alliance for the Mentally Ill.

Spaniol, L., Koehler, M., & Hutchinson, D. (1994). *The recovery workbook: Practical coping and empowerment strategies for people with psychiatric disability,* Center for Psychiatric Rehabilitation, Boston University.

Spaniol, L., Koehler, M., & Hutchinson, D. (1994). *Leader's guide: The Recovery Workbook.* Center for Psychiatric Rehabilitation, Boston University ($4.95 or free with 10 or more copies of *The Recovery Workbook*).

Spaniol, S., & Zipple, A. (1994). The family recovery process. *The Journal, (5)*3. California Alliance for the Mentally Ill.

Straus, D., & Skrinar (1991). Fitness as a viable support for recovery, *Community Support Network News, (8)*1, 4.

Strauss, J. (1992). The person: Key to understanding mental illness: Towards a new dynamic psychiatry, III. *British Journal of Psychiatry, (161)*18, 19–26.

Strauss, J., Hafez, H., Lieberman, P., & Harding, C. (1985). The course of psychiatric disorder, III: Longitudinal principles, *American Journal of Psychiatry, (142)*3, 289–296.

Sullivan, W. P. (1997). A long and winding road: The process of recovery from mental illness. *Innovations and Research, (3)*3, 19–27.

Surgeon General (1999). *Mental health: A report of the surgeon general.* Department of Health and Human Services, Bethesda, MD: United States.

Turner, J., & TenHoor, W. (1978). The NIMH Community Support Programme: Pilot Approach to a Needed Social Reform. *Schizophrenia Bulletin, (4)*3, 319–348.

Unzicker, R. (1989). On my own: A personal journey through madness and reemergence. *Psychosocial Rehabilitation Journal, (13)*1, 71–77.

Unzicker, R. (1994). Stressor, symptom, or sequale; remission, recovery or cure? *The Journal, (5)*3, 16,17. California Alliance for the Mentally Ill.

Wallcraft, J. (1998). *Healing minds: A report on complementary therapies in mental health.* London: Mental Health Foundation.

White, M., & Epston, D. (1990) *Narrative means to therapeutic ends.* New York: W. W. Norton.