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An Overview of Mental Health Recovery

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ABSTRACT

Empirical evidence and personal accounts have demonstrated that many people with severe and persistent mental illness can lead satisfying, meaningful lives. This phenomenon has been termed recovery. A variety of definitions of recovery have been proposed. Lack of consensus on conceptual and definitional issues complicate the measurement and study of recovery. The development of qualitative and quantitative measures of recovery is enriching research on recovery. The integration of recovery goals with evidence-based practices has recently been endorsed. However, relatively little empirical research has addressed the extent to which current evidence-based practices impact recovery. This article chronicles the history of the current focus on recovery in mental health, summarizes available process and outcome definitions, describes current research methods utilized in the recovery literature, and provides a clinical model that integrates recovery with an evidence-based practice perspective.

FOCUS POINTS

- Research evidence and subjective accounts support the notion that people with a severe and persistent mental illness can lead a meaningful life while managing the illness. This has been termed "recovery" in the mental health field.
- Numerous descriptions of recovery as a process and outcome have been proposed.
- Quantitative measures of recovery are currently being developed and studied. Qualitative methods have also come to the forefront in recovery research.
- Six evidence-based practices for people with severe and persistent mental illness have been identified. Although historically viewed as conflicting with the recovery concept, the integration of recovery ideals within an evidence-based framework has been recently endorsed.

INTRODUCTION

The goal of recovery is well understood and appreciated in physical medicine and rehabilitation.[1] People with a chronic medical condition (eg, diabetes) or disability (eg, paraplegia) may not expect an elimination of symptoms or the restoration of functioning. However, it is understood that treatment can help people manage the illness or disability and achieve the best life adjustment possible.[2]

The recovery construct from physical rehabilitation has over time been adopted by the public mental health system. Mental health consumers have shared their stories of recovery in the literature, and consumers and families alike are advocating recovery-oriented programs. In addition, researchers are evaluating the influence of mental health treatments on recovery outcomes, and mental health systems are attempting to develop policies that will enhance recovery outcomes.

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What is meant by mental health recovery? Is recovery possible? How is recovery measured and studied? Can recovery be integrated with evidence-based practices? This article provides a historic overview, synopsis of the current thinking and research on recovery, and model that informs and guides the use of evidence-based mental health interventions to support recovery.

HISTORY OF THE RECOVERY MOVEMENT IN MENTAL HEALTH

Before the 1980s, treatment for people with severe and persistent mental illness (SPMI) focused solely upon symptom management.[3] In addition, schizophrenia, an SPMI, was initially characterized by Kraepelin as a progressively deteriorating illness in which poor outcomes were expected.[4] This prevailing viewpoint was challenged by two sources that demonstrated that people with SPMI were able to lead fulfilling lives while managing symptoms of the illness. First, personal stories of recovery emerged in the research literature, providing initial evidence that people with SPMI had the ability to move beyond the illness.[5-8] Second, the possibility of recovery from mental illness was confirmed by landmark studies.[9,10] These studies showed that 50% to 60% of people with schizophrenia significantly improved or recovered after an average of 32 years. A meta-analysis of international research literature reported that approximately 50% of people with schizophrenia included in studies during the 20th century evidenced substantial clinical improvement after an average of 6 years.[11] Nine additional long-term studies found similar results.[12] In a recent longitudinal study, recovery was repeatedly assessed over 15 years with results suggesting that almost 50% of the sample experienced one or more periods of recovery.[13] Overall, these findings indicate that recovery may involve growth and setbacks as well as periods of rapid change and little change,[1] and discredit the notion of SPMI being defined by an unrelenting, downhill course.

One of the first definitions of mental health recovery was proposed by Anthony[1] as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles...a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness." Anthony compared recovery from SPMI to recovery from physical illness and disability, noting that people can recover from illnesses without necessarily being cured.

The 1990s were subsequently declared the "decade of recovery" by Anthony.[1] During the late 1990s, state mental health systems attempted to incorporate a recovery vision and promote recovery-oriented services. A system with a recovery vision is guided by the notion that people who are consumers of mental health services can lead personally satisfying lives beyond the illness.[14,15] Many states initially developed recovery vision statements for their mental health systems, which explained recovery and showed a commitment to the goal. Some states redefined existing services as recovery oriented, while others developed new programs specifically designed to promote recovery. Common core elements of the recovery programs developed by these states included education about severe and persistent mental illness, consumer and family involvement such as peer-support and self-help networks, support for consumer-operated services, emphasis on relapse prevention and management, incorporation of crisis planning and advance directives, innovations in contracting and financing mechanisms, definition and measure of outcomes, review and revision of policies, and stigma reduction initiatives.[16]

In the current decade, the public mental health system in the United States is continuing to work toward the adoption of recovery principles. Some examples include the 2003 New Freedom Commission on Mental Health, which officially recognized the possibility of recovery from SPMI. The Veterans Administration has recently adopted a recovery model.[4] An expert panel convened at the National Consensus Conference on Mental Health Recovery and Mental Health Systems drafted a national consensus statement on mental health recovery.[17] A textbook devoted to the topic of recovery has been written in an effort to develop a knowledge base.[18] An updated compendium of available recovery measures has been published to facilitate research.[19] To promote system change, recent writings in the recovery literature have outlined characteristics of recovery-oriented systems of care. It has been suggested that recovery-oriented programs be person centered and strengths based by including the person in the design, plan, implementation, and evaluation of services; respecting the person's rights to make his or her own decisions about treatment goals and services; and acknowledging the possibility of the person living a satisfying life beyond the disability.[14] Davidson and colleagues[20] articulated their vision of a recovery-oriented system:

> What primarily will be different about recovery-oriented systems of care, as we envision them, is that these interventions and supports will be provided in ways much more similar to than different from other health care services for other health conditions. The people receiving these services will likewise continue on with their ordinary lives, either recovering from the illness when possible or, when not yet possible, gaining access to the technologies, tools, and environmental accommodations they need to incorporate the illness or disability into their lives as only one component of a multidimensional existence.[20]

Additional features of recovery-oriented services that have been proposed by researchers include communicating a

sense of hope, focusing on all aspects of a consumer's life (eg, spirituality, creativity), helping consumers develop skills and knowledge to effectively manage the illness, supporting efforts to move beyond the effects of the illness, nurturing the positive aspects of consumers' lives in addition to decreasing symptoms and other difficulties, fostering a level of independence that suits the consumer, and promoting the development of support systems.[15,17,21-24] Research has begun to demonstrate the benefits of such recovery-oriented practices.[22]

WHAT IS RECOVERY?

Since the initial conceptualization of recovery by Anthony,[1] a variety of definitions have been proposed by consumers, families, practitioners, and researchers. There currently is no single definition,[25] and some researchers have suggested that recovery defies definition.[26]

Process versus Outcome

The recovery literature is replete with definitions of recovery as both an outcome and a process. As an outcome, recovery refers to a measurable end point often defined by criteria such as being symptom-free, working or going to school for a specified length of time, socializing with peers during the week, or living independently in the community. However, many people with SPMI experience their recovery as a unique and dynamic process.

Recovery as a Process

Consumer Definitions

Given the subjective and highly personal nature of mental illness, consumers have had a stake in the description of recovery. Ralph[27] provided a comprehensive review of consumer definitions of recovery. For example, recovery has been defined as a long process of learning how to live with a mental illness while struggling toward positive goals.[28] Deegan[29] noted, "To me, recovery means I try to stay in the driver's seat of my life...I don't let my illness run me." Other consumers described hope, personal responsibility, education, advocacy, and peer support as being involved in recovery.[30] Schiff[31] commented, "...being recovered means feeling at peace, being happy, feeling comfortable in the world and with others, and feeling hope for the future...it is about knowing and being able to be who I am."

Consumers have also embraced the concept of empowerment as being highly relevant to the process of recovery. This model of recovery emphasizes the principles of hope, achievement of self-defined goals, opportunities for consumers to speak for themselves, an end to discrimination, and healing from within.[32] The Center for Mental Health Services recently invited consumer leaders to discuss and define recovery. Based upon their personal experiences and a review of the recovery literature, the Recovery Advisory Group described recovery as a nonlinear progression through phases of anguish; awakening; insight; action plan; determination to be well; and well-being, empowerment, and recovery.[33] Additional consumer accounts of recovery include the importance of taking responsibility, having structure and organization, and "being like normal people."[34]

Recovery Processes

Processes inherent in and relevant to recovery have been examined using primarily qualitative methodology. Jacobson[35] examined 30 narratives by people who identified themselves as in recovery. Findings suggested four recovery processes, including recognizing the problem, transforming the self, reconciling the system, and reaching out to others. Another research group[36] reviewed experiential accounts of recovery and subsequently identified the recovery processes of finding hope, re-establishing identity, finding meaning in life, and taking responsibility. Additional recovery processes extracted from personal stories include reawakening of hope after despair, breaking through denial and achieving understanding and acceptance, moving from withdrawal to engagement and active participation in life, active coping, no longer viewing oneself primarily as a person with a psychiatric disorder and reclaiming a positive sense of self, and moving from alienation to a sense of meaning and purpose.[37]

In another study,[38] interviews were conducted with a small sample of people with schizophrenia. Their subjective experiences revealed three recovery processes, including controlling crisis, putting it in perspective, and coping with relapse. Based upon consumer accounts and focus group responses, other researchers proposed the recovery processes of having hope, taking personal responsibility, and getting on with life.[39]

Stage Models

Numerous authors have conceptualized stage models of recovery.[40] Three "emotional stages" of recovery were proposed by Baxter and Diehl,[41] who conducted interviews with 40 consumers involved in peer services. The stages included "crisis," during which consumers attempt to recuperate; "decision," such that consumers decide to rebuild the ability to care for themselves and to assume normal life roles; and "awakening," in which consumers attempt to rebuild a healthy interdependence.

Over a 4-year period, consumers were interviewed about their personal experiences with schizophrenia or schizoaf-

fective disorder.[42] Their experiences were categorized into four phases, including being overwhelmed by the disability, struggling with the disability, living with the disability, and living beyond the disability.

Based upon data obtained from qualitative interviews and focus groups with consumers, Young and Ensing[43] developed a three-stage model of recovery. The initial phase involves overcoming "stuckness," which includes accepting the illness, finding hope, and having the desire to change. The middle phase entails regaining what was lost and moving forward. The last phase involves improving quality of life by striving for new potentials and achieving a sense of well being.

The findings from the above qualitative studies have been summarized in the form of a five-stage model of recovery.[36] The first stage, moratorium, is characterized by denial, confusion, hopelessness, identity confusion, and self-protective withdrawal. The second stage, awareness, involves becoming aware of the potential to be someone other than the "sick person" and recognizing the possibility of recovery. The third stage is preparation, in which the person starts working on recovery by acknowledging his or her strengths and weaknesses, learning about mental illness and mental health services, and connecting with peers. The fourth stage, rebuilding, is characterized by the hard work of recovery, including setting and working toward personal goals, taking responsibility for managing the illness, and taking risks. The last stage, growth, is distinguished by knowing how to manage the illness and stay well, having a positive sense of self and confidence in one's ability to manage setbacks, and looking toward the future.

The above definitions and stage models reflect a convergence of views about the fundamental nature of recovery. Recovery appears to involve dynamic and often non-linear movement through multiple stages as the consumer works to gain control of the illness in order to live life more fully. These stages progressively include the themes of hope, acceptance of the illness, and a renewed sense of self.[26] Andresen and colleagues'[36] five-stage model is one of the first attempts to succinctly incorporate a variety of conceptualizations of recovery into a single model and significantly contributes to this growing body of literature.

Recovery as an Outcome

Researchers have also attempted to operationalize recovery as an outcome. The outcome definitions are based on clinical experience as well as quantitative and qualitative research methodologies. Four specific operational definitions of recovery are summarized in Table 1.[13,44-46] All definitions include the criterion of symptom remission or stabilization as well as improved psychosocial functioning, which has been defined in a variety of ways (eg, global rating versus assessment of involvement in social or employment activities). They also require that the criteria be met for varying lengths of time, ranging from 1–5 years. Furthermore, Liberman and Kopelowicz[47] provided an expanded list of criteria for researchers to consider in operational definitions of recovery. This list included symptom remission; working or studying in a normative setting; independent living without supervision of money, self-care skills, and medication; social activities with peers; supportive family relations; recreational activity in normative settings; use of problem-solving skills when faced with a conflict; life satisfaction; positive self-esteem; and participation as a citizen in voting, self-advocacy, neighborliness, and other civic areas.

TABLE 1
OPERATIONAL DEFINITIONS OF RECOVERY

Liberman et al[44]	*Torgalsboen and Rund*[45]	*Whitehorn et al*[46]	*Harrow et al*[13]
1. Brief Psychiatric Rating Scale score of 4 (moderate) or less on positive and negative symptom items for 2 consecutive years	1. A diagnosis of schizophrenia that is not currently present	1. No score greater than 3 (mild) on the Positive and Negative Syndrome Scale	1. Absence of major positive and negative symptoms for 1 year
2. Employment in a competitive job or attendance of school at least 50% of the time	2. No psychiatric hospitalizations for at least 5 years	2. Social and Occupational Functioning Assessment Scale score of ≥60	2. Score of ≥2 on the Strauss-Carpenter work adjustment and social activity scales
3. Independent management of daily activities	3. Global Assessment of Functioning score of ≥65	3. Global Assessment of Functioning score of ≥50	3. No psychiatric rehospitalization as demonstrated by a score of 1 or 2 on the Levenstein-Klein-Pollack scale
4. Participation in social or recreational activity at least once a week			

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The above outcome definitions clearly facilitate the ability of researchers to measure recovery. However, they do not address subjective experience or phenomenology of recovery as emphasized by many consumers. To integrate the process and outcome perspectives on recovery, it may be beneficial to include both quantitative measurement of common recovery themes (eg, social relationships, employment) as well as qualitative measurement of the more phenomenologic aspects of recovery processes or stages, such as feelings of hope and empowerment. Most of the process and outcome definitions are not antithetical but inextricably linked and reflect different perspectives.

MEASUREMENT OF RECOVERY

Quantitative Measurement of Recovery

The multiple definitions of the recovery construct complicate its measurement.[37] There have been recent efforts to develop quantitative measures. The quantitative measures of recovery have been classified into two categories, including surveys and other scales as well as societal indicators.[48] Surveys include measures that assess the absence of symptoms as well as direct measures of recovery and its related dimensions. Societal indicators address the ability to adapt to living in the community (eg, attainment of employment, reduction in hospitalizations).

In 2004, a group of consumers and researchers met to discuss the measurement of recovery. A variety of strategies were utilized to identify recovery instruments including review of the first volume of a compendium, review of the relevant literature, and professional networking. Critical information about each measure was systematically collected from the authors of the instruments. Current available measures are provided in the updated compendium entitled *Measuring the Promise: A Compendium of Recovery Measures*, Volume II.[19] Two types of recovery assessment tools were included, that is, measures of individual recovery and recovery-promoting environments. Measures of individual recovery assess one or more aspects of individual-level recovery, while measures of recovery-promoting environments assess the recovery orientation of services and systems as well as the extent to which programs and services include processes thought to bring about recovery. To date, nine measures of individual recovery and four measures of recovery-promoting environments are available in this compendium. The measures vary in their stages of development with some having not yet been pilot tested, while others have undergone considerable psychometric testing. They also differ in length, method of administration (ie, interview versus self-administration), and source of information (ie, consumer versus family versus professional ratings). The compendium represents a major advancement in the measurement of recovery, and future efforts should be encouraged.

The Role of Qualitative Methodology

As noted above, researchers are also viewing recovery as a highly individualized, dynamic process.[49] This view has received empirical support[50] and validates the experiences of many consumers.[25] This conceptualization, however, makes it difficult to study recovery using traditional quantitative methods, and increasingly qualitative methods are being recommended to understand the recovery process.[50,51] Qualitative methods provide consumers the opportunity to tell their stories and describe the process in their own words, which is consistent with recovery values.

Davidson and Strauss[52] were two of the early researchers to apply qualitative methodology in their study on the role of the sense of self in the recovery process. Qualitative inquiry has since come to the forefront in the study of recovery, [27,35,41,43,51,53-58] and a book has been published about qualitative studies of recovery in schizophrenia.[59] Various qualitative methods have been used such as observation, semi-structured interviews, focus groups, and document analysis, as well as qualitative traditions such as grounded theory, ethnography, and phenomenology. For example, researchers have analyzed personal accounts of recovery to identify factors that play a role in coping and adaptation.[27] Interviews have been used to examine the impact of treatment settings on recovery beliefs.[58] Focus groups have been conducted to explore the meaning of recovery to people with severe and persistent mental illness.[43] A multinational, qualitative study on the processes of recovery was recently completed with 12 individuals in four different countries.[60] The main themes were elucidated in several papers and included how the person deals with difficulties, the role of material resources, the roles of formal and informal health systems, the roles of others, and the roles of social and cultural factors. The above research indicates that qualitative methods can effectively illuminate the process of recovery. However, this type of inquiry is limited by the length of time required to collect and interpret information, the inability to attribute causality to relationships, and potential biases due to differences in consumers' abilities to articulate their experiences. Clearly, quantitative and qualitative methods each have inherent strengths and weaknesses and should be viewed as complementary approaches. Our understanding of recovery will be enriched when both methods are applied.

RECOVERY AND EVIDENCE-BASED MENTAL HEALTH PRACTICES

As the recovery movement has grown in the mental health field, so has the development and implementation of evidence-based practices (EBPs). EBPs are interventions for which there is consistent research evidence of positive treatment outcomes.[61] Six treatments for SPMI have been identified as having a strong empirical base. These include the use of medication guidelines, illness management and recovery, assertive community treatment, family psychoeducation, supported employment, and integrated substance abuse treatment.[62]

Both the recovery movement and EBPs are grounded in a growing research literature. Because the concepts of EBPs and recovery have originated from somewhat different traditions and stakeholder groups, they have sometimes been viewed as conflicting.[63] Recently, however, the compatibility and integration of EBPs with recovery has been articulated in practice and research.[40] Bellack[4] summarized the extent to which current evidence-based treatment recommendations are in line with recovery. Similarly, Glynn and colleagues[15] outlined ways in which the EBP of family psychoeducation is consistent with a recovery orientation.

Others have recommended that recovery goals be used to inform the development, evaluation, and provision of EBPs.[3,14] Anthony and colleagues[50] offered eight specific suggestions of how to incorporate a recovery orientation into EBP research. First, outcomes should reflect a recovery orientation and be endorsed by consumers. Current EBP research focuses upon symptoms and relapse rates at the expense of other important outcomes such as self-efficacy, valued work, decent housing, and enrollment in school, which may be deemed more important by consumers. Second, it is important to include subjective outcomes and qualitative methods since the recovery experience has been found to be unique. Qualitative inquiry is a research method designed to focus upon what the person perceives and experiences as the change process. Third, the use of quasi-experimental and correlational research designs should be continued. It is argued that these research designs can effectively inform the development of EBPs and the design of future clinical trials. Fourth, research should strive to understand why EBPs have not been shown to consistently affect recovery-oriented outcomes in order to modify and improve current EBPs as needed. Fifth, because first-person accounts of recovery indicate that the presence of another supportive person is an important factor in their success, future research should more closely examine the role of the helper/consumer relationship in EBPs. It is possible that non-specific factors may be viewed as more helpful than a particular technique or intervention. Sixth, since EBPs represent comprehensive programs that include several components, the use of dismantling studies will identify the specific components that are necessary and account for positive outcomes. This is an important issue to address given political and funding pressures. Seventh, EBP research should test the efficacy of treatments in a variety of cultures and contexts. There is currently a lack of evidence that points to positive outcomes using EBPs with minority groups and various geographic settings. Last, it is recommended that research examine features of EBPs that are based upon recovery values (eg, consumer involvement in the design of programs) to address their impact on outcomes. These values may determine the program's potential in addition to the specific components and structure of the program itself.

The concept of community integration proposed by Bond and colleagues[64] effectively clarifies the relationship between EBPs and recovery. Community integration has been defined as helping consumers "move out of patient roles, treatment centers, segregated housing arrangements, and work enclaves, enabling them to move toward independence, illness self-management, and normal adult roles in community settings."[64] It is viewed as the external manifestation of the recovery experience and has the potential to influence the internal experience of recovery such as having hope and self-confidence. The current EBPs are believed to promote community integration and maximum social and economic independence, which subsequently facilitates the internal experience of recovery, pointing to the potential role of EBPs in recovery. Bond and colleagues[64] further outlined ways in which each EBP may contribute to community integration.

Despite these suggestions, the extent to which EBPs foster recovery is presently unclear.[65] There is simply a lack of studies that have asked the relevant questions. Due to the paucity of data, researchers have drawn contradictory conclusions about the impact of EBPs on recovery-related outcomes.[50,64] Thus, there is a critical need for future researchers to systematically address the influence of EBPs on recovery processes and outcomes.

It is important to acknowledge that the EBP movement is not without its critics. Most notably, the criteria for establishing the status of treatments as evidence based have been said to reflect priorities of the research community rather than consumer preferences (eg, relapse rates versus empowerment). This approach also downplays potentially effective treatments that have yet to reach EBP standards, particularly consumer-run services.[66]

THE ROLE OF EVIDENCE-BASED PRACTICES IN RECOVERY

As researchers begin to evaluate the ways in which recovery is facilitated by current evidence-based practices, it is important for consumers to receive services that improve the ability to function in their environments.[67] The basic needs of food, clothing, safety, and shelter must first be met, which serve as a secure base from which to move forward in recovery.[68] For some consumers, this may involve offering assistance in accessing Social Security benefits as well as supervised housing programs or subsidized housing. In addition, although medications are necessary in managing symptoms, medications alone have been found to be insufficient.[69]

Peer support, in the form of mutual support groups, consumer-run services, or consumers as providers within treatment settings may promote recovery by countering stigma and offering hope and motivation to work toward a better future.[70] Throughout a person's recovery, it may additionally be useful to provide EBPs because research has shown that they reduce symptoms and relapse, promote stabilization, provide education, build skills, and encourage the realization of consumer goals. EBPs may also play a role in promoting the specific processes involved in recovery, which is currently being examined. The authors of this article have proposed a model in which the selection of EBPs are linked to each stage of recovery (Table 2). The stages of recovery proposed by Andresen and colleagues[36] guided the development of this model. Their work is based upon research and represents an integration of all stage models currently available in the recovery literature.

The proposed model is intended to call attention to the relative contribution of EBPs during the various recovery stages and to stimulate thinking about the role of EBPs throughout recovery. While the EBPs may contribute quite broadly to all stages, some EBPs are likely to play a larger role during certain phases of recovery, which is reflected in the model presented. This authors of this article also recognize that the path to recovery is not linear and that consumers may move back and forth among the various stages. Therefore, frequent assessment of the consumer's involvement in the recovery stages may be helpful throughout the course of treatment and will better inform treatment planning.

Andresen and colleagues[36] note that consumers experience denial and confusion in the initial recovery stage, identified as "moratorium." They may feel hopeless about their future, confused about the biologic and cognitive changes they are experiencing, and withdraw from others in order to protect themselves. At this beginning point in recovery, pharmacologic treatments according to established guidelines[71] are generally useful in diminishing the impact of symptoms. The EBP of assertive community treatment[72] (ACT) may be of particular benefit because it is designed for people facing the most challenges[73]; further, its assertive outreach approach entails working with the person in his or her own environment, providing assistance with activities of daily living, and assisting the person in obtaining needed services. During this stage, not only does the consumer experience a sense of confusion and hopelessness, but the family does as well. Thus, the EBP of family psychoeducation[74] is of use in the "moratorium" stage. Family psychoeducation is an EBP which invites the family to participate fully in the treatment process and encourages a strong support network for the consumer.

During the second stage of recovery, called "awareness," consumers begin to feel hopeful about leading a better life and realize that recovery is possible. They learn that one can be viewed as a person with many different aspects, including an illness, rather than viewed wholly as a "sick person."[36]

TABLE 2
A RECOVERY AND EVIDENCE-BASED PRACTICES FRAMEWORK

	Stages of Recovery				
Evidence-based Practices	***Moratorium***	***Awareness***	***Preparation***	***Rebuilding***	***Growth***
Medication	X	X	X	X	X
Assertive community treatment	X	X	X	X	X
Family psychoeducation	X	X	X	X	X
Illness management			X	X	X
Supported employment				X	X
Integrated substance abuse treatment	X	X	X	X	X

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Medication management services, ACT, and family psychoeducation are useful in this stage. Medications are continued particularly since it has been found that they not only reduce symptoms but also help to prevent the recurrence of symptoms. The provision of ACT services may help maintain the person's psychiatric stabilization and engagement in mental health services. In addition, family psychoeducation may engender hope as well as facilitate awareness of recovery by providing opportunities for consumers to meet others who are progressing in recovery and by presenting information about the recovery concept and its supporting research literature during an educational workshop.

The third stage of recovery, "preparation," involves preparing for the work involved in recovery. This work may involve evaluating values, strengths, and challenges; beginning to learn about mental illness and strategies for managing the illness; and becoming more involved with treatment groups or peers.[36] Medication management and ACT services again play a role in helping the person maintain stability and treatment involvement. To help consumers develop individualized coping skills, ACT works with consumers individually, while family psychoeducation offers information to families and consumers through a workshop and structured problem-solving exercises. The highly structured EBP of illness management,[75] which may be provided individually or as a group, is particularly useful during this recovery stage. Illness management is designed to provide consumers information about mental illness and how to cope more effectively.

During the fourth stage of "rebuilding," consumers begin the "hard work of recovery." They strive to develop a positive self identity and pursue personally meaningful goals, which may require a re-evaluation of previous goals and dreams. Consumers also take responsibility for managing the mental illness and resuming control of their lives, which may involve taking risks and managing potential setbacks without losing hope.[36] Medications and ACT continue to assist consumers in maintaining stability. Members of the ACT team may also provide educational and/or employment services for consumers who have a desire to pursue these goals. Family psychoeducation promotes rebuilding by assisting consumers with setting and working toward goals in a step-by-step fashion. Illness management provides opportunities for consumers to explore areas of their lives in which they are most and least satisfied and teaches the importance of establishing one or two obtainable goals during recovery. This EBP also provides information about how to develop a detailed relapse prevention plan, which may assist in managing a potential setback. Personal[76] and cognitive therapy for schizophrenia,[77] which have been identified as two specific illness-management programs, may assist the person in forging a positive identity and exploring meaningful life goals. The EBP of supported employment[78] may be introduced during this stage to assist consumers in finding job placements if their goals involve employment.

The last stage of recovery has been referred to as "growth." At this stage, consumers are able to manage the illness effectively and are, thus, able to lead a life with meaning, resiliency, and a sense of confidence in their ability to manage potential setbacks. They are also able to hold a positive self identity and realize that the experience of having a mental illness has strengthened them.[36] Each of the EBPs may play a role during this stage of recovery. For example, medications and ACT are naturally designed to assist the person in managing the illness and symptoms, though the ACT team's focus will most likely shift to supporting recovery-oriented goals. Family psychoeducation and illness management provide opportunities for the person to learn strategies to manage the illness effectively and make progress toward goals. The EBP of supported employment may assist consumers who find meaning in holding a job. Employment provides several benefits for people in recovery, including "additional income...improved self-esteem...a daily structure, a reason to get out of bed in the morning, an identity, and an extended social network."[69] Employment may also positively influence the internal experiences of recovery, such as feelings of hope and self-confidence.[64]

The EBP of integrated substance abuse treatment is a necessary treatment for many consumers. More than 50% of people with SPMI are further challenged by substance abuse, creating a high risk for numerous negative outcomes. Research has shown that treating the substance use disorder and mental illness together promotes recovery.[79] It is recommended that one core team provide integrated services through all stages of recovery from "moratorium" to "growth" and promote consumer motivation to reduce or abstain from the negative effects of substance abuse.

Because ACT in particular has been viewed by some consumers as restrictive and paternalistic, it is important to note that ACT was specifically developed for a subset of consumers who were unable to function independently in the community. ACT was intended to provide the structure and support necessary for successful community life. Therefore, it is essential to recognize that ACT is utilized as the consumer identifies or requests a need for it, and while engaged in ACT, consumers maintain a decisive voice in which services they receive and the way in which they receive them.[73]

For example, one consumer, who will be named Mary, was positively affected by the use of a combination of EBPs in her recovery process. Initially, the effects of illness caused Mary to be unable to take of her basic needs and self independently, requiring that she live with her family for support. In the "moratorium" stage, Mary accepted her need for medications and recognized the negative effects of substances use. Although an ACT program was not available, intensive case-management services and family psychoeducation were provided. As Mary and her family learned about the illness, they entered the stages of "awareness" and "preparation," where they came to understand and accept the illness process as well as learn strategies to cope with illness effects. Individual illness-management sessions with Mary's therapist significantly facilitated this process. The stage of "rebuilding" emerged as Mary and her family began to apply the learnd coping strategies in everyday life in a step-by-step manner. Although the "rebuilding" stage had forward and backward movement, over time the accumulative effect of improved coping facilitated a sense of hope and confidence in Mary. She was able to seek supportive employment and educational opportunities, which encouraged her independence in the "growth" stage. Currently, Mary lives independently with the support of friends and family, works part-time, and attends school. She engages in public speaking related to mental illness and has become a peer counselor. Most importantly, Mary reports being happy and satisfied in her life.

The framework described represents an attempt to clinically integrate EBPs with a stage model of recovery.[36] EBPs and the recovery construct are not contradictory but instead can be viewed as complementary when offering treatment services during certain phases of recovery. In addition, when offering EBPs as treatment options to consumers, it is important to utilize such recovery principles as self-direction, empowerment, and respect. Both EBPs and recovery can be used to inform mental health policy and research.

CONCLUSION

Recovery is a recent movement in the mental health field that provides much hope and inspiration to consumers and families. The personal accounts of consumers and longitudinal studies demonstrate that recovery clearly is possible. A variety of definitions of recovery have been proposed and there is some debate as to whether it is more appropriate to view recovery as an outcome or a process. The integration of the recovery movement within an evidence-based practice framework has also been recently discussed in the literature. Although quantitative and qualitative methods are frequently viewed as incompatible, both methods may be of most benefit in recovery research.

However, the recovery movement has its critics. Practitioners and some researchers are concerned that the term is overused and that the case for recovery is overstated, setting unrealistic expectations and promoting additional stigma.[80,81] Thus, future research efforts that include all stakeholders have the best chance for a balanced perspective and will establish a solid research base for recovery.

A recovery vision has been articulated. Consumers, families, practitioners, and researchers now share the common goals of educating other stakeholders about the possibility of recovery and developing systems of care that promote recovery. For many people with severe and persistent mental illness, recovery is not only a possibility but a reality. ***PP***

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