Community Mental Health Journal, Vol. 41, No. 2, April 2005 (© 2005)
DOI: 10.1007/s10597-005-2649-6

Implementing Recovery Oriented Evidence Based Programs: Identifying the Critical Dimensions

Marianne Farkas, Sc.D.
Cheryl Gagne, M.S.
William Anthony, Ph.D.
Judi Chamberlin

ABSTRACT: In the decades of the 1990s many mental health programs and the systems that fund these programs have identified themselves as recovery-oriented. A program that is grounded in a vision of recovery is based on the notion that a majority of people can grow beyond the catastrophe of a severe mental illness and lead a meaningful life in their own community. First person accounts of recovery and empirical research have led to a developing consensus about the service delivery values underlying recovery. The emphasis on recovery-oriented programming has been concurrent with a focus in the field on evidence-based practices. We propose that evidence based practices be implemented in a manner that is recovery compatible. Program dimensions for evidence based practice, such as program mission, policies, procedures, record keeping and staffing should be consistent with recovery values in order for a program to be considered to be recovery-oriented. This article describes the critical dimensions of such value based practice, regardless of the service the recovery oriented mental health programs provide (e.g., treatment, case management, rehabilitation).

Marianne Farkas is affiliated with the World Health Organization Collaborating Center in Psychiatric Rehabilitation Boston University, Center for Psychiatric Rehabilitation.
Cheryl Gagne and William Anthony are affiliated with the Boston University Center for Psychiatric Rehabilitation.
Judi Chamberlin is affiliated with the Center for Psychiatric Rehabilitation; and National Empowerment Center.
The development of this paper was supported in part by the National Institute of Mental Health, Rehabilitation and Health Services Research of Serious Mental Disorder Research Program, #5R24MH57933.
Address correspondence to Marianne Farkas, Boston University, Sargent College of Health and Rehabilitation Sciences, Center for Psychiatric Rehabilitation, 940 Commonwealth Ave. West, Boston, MA 02215; e-mail: mfarkas@bu.edu.

© 2005 Springer Science+Business Media, Inc.

The aim of this first attempt at conceptualizing recovery-oriented mental health programs is to both provide direction to those involved in program implementation of evidence based mental health practices, as well as providing a stimulus for further discussion in the field.

KEY WORDS: recovery oriented mental health program dimensions; evidence based practice; values based practice; program mission; policies; procedures; record keeping; staffing.

INTRODUCTION

One of the most pressing problems facing the mental health field today is our lack of knowledge about the interventions and services that will help people recover from severe mental illnesses. Program administrators and therefore service delivery over most of the last century, have been heavily influenced by the mistaken assumption that people with severe mental illnesses do not recover and, in contrast deteriorate over time (Bond et al., 2001). The President's New Freedom Commission on Mental Health (2003) concluded that the mental health system is "not oriented to the single most important goal of the people it serves – the hope of recovery" (p. 3). Programs have been designed to fend off relapse and deterioration and, more recently, to maintain people in the community (Anthony, Cohen, Farkas, & Gagne, 2002). As a result, much of the existing evidence based practice research was conceived without an understanding of the emergence of the recovery concept (Anthony, Rogers, & Farkas, 2003). Program development and planning implications of evidence based practice research are deficient in speaking to the possibilities of recovery. The President's New Freedom Commission on Mental Health (2003) begins its report with a vision statement: "We envision a future when everyone with a mental illness will recover...a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning and participating fully in the community" (p. 1). This paper is an initial effort in bridging the gap between evidence-based practice and the vision of recovery.

International and U.S. longitudinal studies of recovery from major mental illnesses have over the past 30 years demonstrated recovery rates of between 49 and 68% (Harding, in press). Yet it is only within the last decade of the 20th century that program administrators and developers became conversant with the notion of recovery from severe mental illnesses. There is a growing body of literature examining the concept of recovery from mental illnesses, its definition, process, phases, tasks and outcomes (e.g. Anthony, 1993; Farkas, Gagne, & Anthony,

2001; Harding & Zahniser, 1994; Davidson & Strauss, 1992; Spaniol, Gagne, & Koehler, 1999; Spaniol, Wewiorski, Gagne, & Anthony, 2002). People with psychiatric disabilities have published their experiences of recovery (Deegan, 1990, 1993; Fisher & Ahern, 1999; Mead & Copeland, 2000; Ridgway, 2001; Spaniol et al., 1999; Sullivan, 1994; Unzicker, 1989; Weingarten, 1994), and with like minded professionals are advocating for system and agency strategies to facilitate recovery (e.g., Frese, Stanley, Kress, & Vogel-Scibilia, 2001; Jacobson & Greenley, 2001; Torgalsboen & Rund, 1998). Increasing number of states (Beale & Lambric, 1995; Jacobson & Curtis, 2000; State of Wisconsin Blue Ribbon Commission on Mental Health, 1997), as well as entire countries like New Zealand (Lapsley Waimarie Nikora, & Black, 2002) are aligning their vision and mission with a recovery philosophy.

Concurrent with these attempts to embed the vision of recovery in mental health programming has been the impetus for evidence-based practice within these programs. The term evidence based practices include "promising practices" that are accumulating evidence to become designated as evidence based practices (Anthony et al., 2003). An initial group of evidence based practices have been identified (Bond et al., 2001; Sanderson, 2002; Torrey et al., 2001). Evidence based practice has been, in fact defined as "the integration of best researched evidence and clinical expertise with patient values" (Institute of Medicine, 2001). However, relatively little description is given to the value base for these practices (Drake et al., 2001). While the value base underlying evidence based practices can in theory reinforce recovery (Drake et al., 2001), no attempt has been made to explicate recovery values in evidenced based practices, nor to detail how these recovery values might be translated into specific program dimensions. Based on commonly accepted values underlying the notion of recovery, this article proposes recovery-oriented program dimensions that are compatible with evidence-based practices, and that can strengthen evidence based practice implementation. Recovery-oriented program dimensions can guide the entire range of mental health services (e.g., case management, treatment, rehabilitation) including those already identified as evidence based.

THE ESSENTIAL INGREDIENTS OF A RECOVERY ORIENTED MENTAL HEALTH PROGRAM (ROMHP)

In order to identify the essential ingredients of a ROMHP it is important to define what is meant by a *program*. A *program* consists of the

administration, staffing and procedures for the delivery of any service (e.g., treatment, rehabilitation) for which the program is responsible. A program may be organized to deliver more than one service. For example, an ACT program may provide case management, treatment, crisis intervention and rehabilitation services in a specific way detailed through its program structures and staffing. A self-help program may provide crisis intervention and advocacy. Any one of the preceding program examples could be a recovery-oriented program depending upon the extent to which its program structures and staffing incorporate the basic values of recovery. A ROMHP is characterized by program structures such as mission, policies, procedures, record keeping and quality assurance that are consistent with fundamental recovery values. Similarly, staffing concerns such as selection, training and supervision are guided by the fundamental values of recovery.

Based on the present state of our knowledge about what constitutes recovery, its process and its outcomes, it is possible to identify some key ingredients of a recovery oriented program, regardless of which evidence based practice is used. When evidence-based practices are developed, described and replicated (Torrey et al., 2001), possible important philosophical elements of a practice may be omitted because they are not empirically linked to the traditional outcomes reported. Yet some features of a program are important, not necessarily because there is evidence that they produce traditional outcomes such as increased community tenure or employment rates but because they are, from a values perspective, important to the overall approach and can significantly alter the consumer's personal experience of the program and their unique process of recovery (Anthony, 2001; Anthony et al., 2003). A ROMHP is made up of such value-based ingredients regardless of the specific mental health service that it delivers.

VALUES BASED PRACTICE: THE FUNDAMENTAL VALUES OF A ROMHP

Values Based Practice (VBP) explicates the values or guiding principles that are the underlying beliefs held by the program. VBP designs and monitors programs based on explicated values. VBP guides the way in which staff are hired, trained and supervised. While there are many values that may be associated with recovery-oriented services, there are at least four key values that support the recovery process and that appear to be commonly reflected in the consumer and recovery litera-

TABLE 1

Key Recovery Values

Value	Description
Person orientation	The service focuses on the individual first and foremost as an individual with strengths, talents, interests as well as limitations, rather than focusing on the person as a "case", exhibiting indicators of disease.
Person involvement	The service focuses on people's right to full partnership in all aspects of their recovery, including partnership in designing, planning, implementing and evaluating the service that supports their recovery.
Self-determination/choice	The service focuses on people's right to make individual decisions or choices about all aspects of their own recovery process, including areas such as the desired goals and outcomes, preferred services used to achieve the outcomes, preferred moments to engage or disengage in services.
Growth potential	The service focuses on the inherent capacity of any individual to recover, regardless of whether, at the moment he or she is overwhelmed by the disability, struggling, living with or living beyond the disability.

Adapted from Farkas, Anthony, and Cohen (1989).

ture. These values are: person orientation, person involvement, self-determination/choice and growth potential), initially described by Farkas, Anthony, and Cohen (1989) (see Table 1)

Person Orientation

Davidson & Strauss (1992) mention the importance of understanding the strengths and weaknesses of the individual. "Person orientation" implies that individuals are more than what they may demonstrate in the limited roles of "patient" or "client" or "service recipient". The majority are adults, who may also have roles as fathers, mothers, brothers, students, workers, and advocates. Individuals represent the full range of human interests, talents, intellect and personalities that are evident in the general population. First person narratives convey that people with psychiatric disabilities appreciate when mental health professionals express interest in them as a person and in roles other than as "patient" (McQuillan, 1994; Weingarten, 1994). They may feel damaged by professionals who refuse to connect in a more holistic way (Deegan, 1990).

Person Involvement

Research data in rehabilitation suggest that outcomes are better for people who have an opportunity for meaningful involvement in the planning and delivery of their services (e.g., Majumder, Walls, & Fullmer, 1998). Consumer involvement in designing and delivering services (e.g., program planning, implementation and evaluation) is seen as a critical component of a quality management system for a mental health service (Blackwell, Eilers, & Robinson 2000).

Self-determination/choice

Several mental health program models such as psychiatric rehabilitation (Farkas, Cohen, & Nemec, 1988), supported housing (Carling, 1995), psychosocial clubhouses (Beard, Propst, & Malamud, 1982) and some case management programs (Pyke, Lancaster, & Pritchard, 1997) articulate the values of choice and partnership. Davidson and Strauss (1992) note, based on their qualitative research, that coercion has the effect of diminishing, rather than strengthening the self. "Getting someone simply to 'comply' with treatment may in fact end up having an effect opposite to the one intended, for example, if it leaves the

patient continuing to feel controlled from the outside, only now by her/his doctor rather than by her/his hallucinations" (Davidson & Strauss, p. 138). Two studies that have examined vocational programs and client choice, report a positive relationship between choice and rehabilitation outcome (Becker, Drake, Farabaugh, & Bond, 1996; Bell & Lysaker, 1996).

Growth Potential

Hope for the future is an essential ingredient in all recovery-oriented services. A value on "growth potential" implies a commitment to maintaining hopefulness in both service participants and their practitioners. It includes evaluating progress towards growth, adjusting services to allow progress to be noticed or acknowledged, as well as altering services to improve progress.

VALUES DRIVEN DIMENSIONS: ORGANIZATION AND STAFFING

A ROMHP is made up of two dimensions: *organization/administration* and *staffing*. The organization/administration dimension includes the structural components of the program that provide an institutional framework for recovery efforts based on the key recovery values. The staffing dimension ensures that the people in the organization deliver the service in a manner consistent with the values of recovery. Table 2 provides a summary of the key recovery-oriented mental health program ingredients, along with examples of standards based on recovery values and standards that are not. The text that follows amplifies on the examples in Table 2.

The Organization/Administration

The organization/administration dimension includes components such as the program mission, policies, procedures, record keeping systems, quality assurance mechanisms, the physical setting of the program itself, and the network of services either linked to or controlled by the program (Farkas et al., 1989).

Mission. A ROMHP is guided by a mission that reflects the key values at a minimum. A mission statement identifies intended outcome(s) in behavioral terms, rather than simply the provision of service

TABLE 2

Examples of Values Based Recovery Standards by Program Dimensions

Program dimensions	*Example of value based recovery standard*	*Example of current non recovery standard*
Organization and administration		
• Mission	To help people improve their functioning so that they can be successful and satisfied in the environment of their choice (*person orientation, self-determination/choice, growth potential*).	To provide comprehensive treatment and rehabilitation services to clients that emphasizes continuity of care (*focus on service delivery not outcome; no self determination).*
• Policies	People will have the opportunities and assistance necessary to choose and plan for whatever services they want to promote their own recovery (*self-determination).*	People must attend the day treatment center to be accepted as a resident in Green valley apartments. (*no self-determination; no individualization that would reflect a person orientation*).
• Procedures	A detailed list of orientation steps provided in different individualized communication modalities to ensure that clients receive program information based on what they want to know and how they take in information. Orientation includes	A generic orientation packet is provided to each new client (*while this may be helpful for some, it is not a sufficiently comprehensive procedure to ensure that most clients will be engaged in understanding what they are entering; no person orientation).*

	information about what the program offers, cannot offer, what it expects, how clients can give feedback (*person involvement*).	
• Record keeping	Records are designed to include process and outcome measures related directly to the program's mission *(growth potential)*.	Records are designed to capture service utilization measures (*while important for administration, does not provide possibility to change program based on results of service provision; no growth potential*).
• Quality assurance	Monitoring program outcomes include measures selected by clients (*person involvement; self-determination)*.	Monitoring program outcomes only reflect measures dictated by state regulations (*programs can be in compliance but have little relevance to clients; no person involvement)*.
• Physical Setting	Program facilities are for everyone's use (*person orientation)*.	Bathrooms are limited to those for staff and those for clients (*sets a tone of "us the well, you the unwell"; no person orientation)*.
• Network	Program links to services in both community and professional settings (*person orientation*).	Program staff provide on-site recreation activities, on site chaplain services, crafts and on site educational opportunities (*creates a segregated mental health service universe; no growth orientation)*.

TABLE 2 *(Continued)*

Program dimensions	*Example of value based recovery standard*	*Example of current non recovery standard*
Staffing		
• Selection	Staff are hired based on their knowledge, attitudes and skills in recovery (*consistent with the basic recovery values).*	Staff are hired based on their credentials and years of service *(assumes staff are taught recovery knowledge, attitudes and skills in their credentialing process; no recovery values considered).*
• Training	Staff training includes interaction and interviews with individuals who are living beyond their disability/have recovered (*growth potential).*	Staff training focuses exclusively on issues of relapse, non-compliance, dangerousness and risk assessment (*prepares staff to handle difficulties but not success; no growth potential; no person orientation).*
• Supervision	Promotions, rewards and supervisor reinforcement reflects staff's ability to demonstrate the knowledge, attitudes and skills necessary for recovery and recovery outcomes *(all recovery values).*	Promotions, rewards and reinforcement reflects measures such as: years of service; yearly attendance; number of training events completed. (*Rewards presence not competence; no recovery values*).

to an identified target population (Farkas et al., 1988). Some recovery outcomes that have been identified in the literature include: gaining or regaining the role of worker, community member, tenant, or student; experiencing increased success and satisfaction in these roles; reducing or controlling symptoms; increasing a sense of empowerment; increasing feelings of well being; increasing measures of physical and/or spiritual health; and increasing a sense of self-esteem (Campbell & Schraiber, 1989; Mead & Copeland, 2000; Ralph, Lambric, & Steele, 1996; Spaniol et al., 2003; Young & Ensing, 1999).

Mission statements should not be simply bureaucratic statements, unrelated to the everyday provision of services. They should drive program development and service delivery. An effective recovery-oriented mission is known, discussed and understood by all clients and providers of the service. It should be posted in locations that are easily read by everyone entering or using the service *(person involvement)*.

Policies: A ROMHP has policy statements that, at a minimum, reflect the four recovery values. Policy statements should provide general value based principles for the delivery of the service's unique process of assessment or diagnosis, planning, and interventions. For example, a policy statement might read: "All Blue Hill's program staff will refer to individuals receiving services in 'person first' language". All policy statements are written in language that reflects respect for the individuals using the service (*person orientation).* Reflecting *self-determination*, a policy statement may read: "People may choose the intensity of support services provided by the program". Policies reflecting *growth potential* might require the development of quality assurance mechanisms that allow, for example, program data on processes and outcomes to be evaluated with respect to the clients' recovery goals.

Policies can be written for any aspect of the program. For example, policies can provide principles for areas such as record keeping (e.g., "Records will be available to the person, at any time they request it" – *self-determination*); quality assurance (e.g., "Consumers will be recruited to be integral members of the program evaluation team, helping to design program evaluation questions as well as to interpret the results" – *person involvement*) or policies about the setting itself (e.g., "The architectural layout, building resources and decorations within the setting will be welcoming to clients, and visitors as well as staff" – *person orientation*).

Procedures: In order to ensure that policies are meaningful directives for programs, ROMHP develops procedures for each policy. Procedures

are designed to detail the steps that staff should perform to deliver the engagement, diagnostic, planning, intervention and disengagement or termination components of a program. For example, a policy may state: "Participants will be actively involved in the service process". Some of the procedures used to put this policy into practice may detail how those entering the program will be oriented in order to begin engaging the individuals in the program (*person involvement).* This may include how to select the preferred orientation format (written material, discussion or both), for example. Based on a policy of program choice, another set of procedures may detail how to organize activities within the program so that program participants have an opportunity to choose *whether* and *when* they want to engage in a specific activity *(self-determination)*.

Record keeping: Record-keeping reflects the four basic values as well. For example, records are designed not only to facilitate staff's documentation efforts but also to facilitate program participant's ability to read them (*person involvement*). This includes issues such as large enough spaces for writing to be legible and using everyday language as much as possible in the documentation system. Records should reflect both what a person's strengths, talents, and interests are as well as what a person has difficulty with (*person orientation; growth potential*). In addition, procedures should be in place that gives clients either copies of their own records or the ability to review their records with a minimal amount of waiting (*self-determination*). Records should be organized so that clients are, at a minimum, able to write comments about what is recorded (*person involvement*) or ideally, able to change what is recorded if necessary (*self-determination*).

Quality assurance: Accountability has become a programmatic aspect of ever increasing importance. ROMHP quality assurance mechanisms allow supervisors and administrators to monitor the quality with which services are delivered. These include the use of service plans that are action-oriented, behaviorally written, and developed by both staff and those using the services, so that progress can be easily monitored (*person involvement; growth potential).* In addition, ROMH programs involve all participants (staff, supervisors, consumers) in developing, planning and implementing the quality assurance mechanisms *(person involvement)*. For example, an ROMH program may choose to organize an ongoing Quality Management Team with representation from of all groups to accomplish this. Outcomes that are monitored include those selected by consumers (e.g., goal attainment, satisfaction with services and process) (*person involvement, self-determination)*.

Physical Setting: The physical environment of a program provides significant cues to those entering the setting, as to the kind of service provided and its values. An ROMH program makes an effort to welcome individuals using the services as well as professional visitors. Bathrooms, coat racks and coffee service set out in reception areas are for everyone's use, rather than being categorized as those used by clients and those used by staff and visitors (*person orientation*). A ROMH program asks individuals receiving their services for input regarding decorating the setting, architectural or building resources that are required, in order to provide a welcoming and supportive environment (*person involvement*).

Network of services: A ROMHP designs its services to link with or engage all types of services whether they occur in a general community environment (e.g., YMCA, places of worship, adult education centers) or in a formal mental health setting. While a ROMHP can advocate for the adoption of recovery oriented values in services or environments to which it links, or services or environments from which it accepts referrals or applications, the program can only dictate actually policies for those services which are within its own control.

Staffing

People with psychiatric disabilities indicate that the most critical facilitator or barriers to their own recovery are how people interact with them (Kramer & Gagne, 1997). Program dimensions for staff include components describing how programs select, train and supervise staff who are facilitating their clients' recovery.

Selection: In order to ensure that a ROMHP is delivered in a way that is consonant with recovery values, it is critical that staff candidates come to the program with the basic knowledge, attitudes and skills needed to promote recovery. Basic knowledge includes knowing the current research with respect to recovery and recovery outcomes as well as, for example, research related to the role of prejudice and discrimination as obstacles to recovery. Basic attitudes include the extent to which the four key values are incorporated into a candidate's way of thinking about individuals with disabilities or psychiatric histories. For example, does the person believe in *involving* participants in all aspects of their service process? Can they give examples of how they think this might be done? Does the candidate demonstrate a belief in *growth potential* or hopefulness? Do they have the skills to act on their values? Basic skills include skills such as the skill of engaging an individual in

a partnership, inspiring hopefulness, connecting with that individual in a personal way, as well as supporting and facilitating the individual's recovery journey. Consistent with ROMHP emphasis on *person orientation* and *self-determination*, ROMHP value staff who have personal experience with mental health issues. A ROMH program assigns priority to those candidates who have both the required demonstrated competencies and consumer/survivor or ex-patient experience to bring to their work.

The selection process includes both in-depth interviews with potential staff and specific methods of directly assessing incoming staff's knowledge, attitudes and skills related to the recovery values (e.g., audiotape samples of client–staff candidate helping interviews and arranging for a trial visit so that the candidate can spend some hours or a day in the program). In addition, in keeping with the value of person involvement, ROMHP selection process includes program participants in a meaningful way. For example, this can include helping to determine selection criteria for new staff, interviewing staff candidates, reviewing resumes or providing input into the selection decisions.

Training: In addition to providing staff with training on aspects of the particular kind of ROMHP involved (e.g., research on new medications, clinical techniques for a treatment program, on effective means for networking and advocating for new services for case management programs), ROMHP designs training programs reflecting recovery values to increase staff knowledge, positive attitudes and skills. Providing staff with the resources to access new information consistent with these values (e.g., certain journal subscriptions, conferences, seminars), opportunities to meet with and understand the experiences of those who are recovering, as well as designing more long term competency building training programs compatible with these values, all serve to increase staff's ability to deliver a ROMHP. Indirect methods of training, such as involving new staff in teams whose values are compatible with recovery can also prove effective. For example, increasing staff's expectation of improvement *(growth potential)* may be accomplished by involving new staff in team meetings where higher expectations for outcomes are the norm (Alexander et al., 1997).

Supervision: Organizational climate has proven to be an important predictor of positive service outcomes (Glisson & Hemmelgarn, 1998; Mayer & Schoorman, 1992). Organizational climate is comprised of attitudes shared by staff about their work. Supervision is an important factor in promoting a positive organizational climate. Supervision ses-

sions include a focus on recovery principles and competencies to ensure that recovery values are indeed translated into action in the program. For example, supervisors reinforce staff discussions of participants' strengths and possibilities in team planning and review meetings *(growth potential).* Supervisors review ways in which staff facilitates participants in making well-informed decisions throughout the service process (*self-determination)*, even when staff disagree with the decisions. The supervisory process itself should be consistent with the recovery values. In other words, the process should involve staff, should focus on strengths as well as limitations, should concentrate on setting meaningful professional goals for improvement with respect to the delivery of recovery services as well as training plans to achieve the goals.

CONCLUSION

Evidence based practice, while able to produce specific outcomes such as reduced symptomatology, decreased hospitalization, fewer relapses or improved employment, may vary on its compatibility with recovery values and ingredients. We do not know at this time whether or not a values based practice adds unique outcome variance, either through improving the intended outcomes of the evidence based practice or by impacting outcomes more closely related to recovery (e.g., self-esteem, empowerment, well being). A program's ability, however, to describe a particular evidence based practice in relation to these ingredients can benefit the field in several ways. Consumers and advocates will have another set of criteria to more specifically evaluate the types of services they will receive from a particular organization. Administrators and program developers can evaluate how many recovery-oriented program dimensions their setting actually contains and develop plans for those areas in which they are not as strong. Researchers can more accurately describe the ingredients of the programs they research so that generalization issues can be addressed more specifically. The conceptualization of program dimensions by recovery values reflects our present knowledge about what values are believed to promote recovery practices for participants of mental health programs. It is our intent that these proposed ingredients be used to further the dialogue about the concept of recovery and its implication for evidence based service delivery. Future work can serve to further refine these recovery oriented program dimensions so that they can serve as a

guide to the development of more comprehensive recovery-oriented mental health programs and contribute to making the vision statement of the President's New Freedom Commission on Mental Health a reality.

REFERENCES

Alexander, J. A., Lichtenstein, R., Daunno, T. A., McCormick, R., Muramatsu, N., & Ullman, E. (1997). Determinants of mental health providers' expectations of patients' improvement. *Psychiatric Services, 48*(5), 671–677.

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

Anthony, W. A. (2001). The need for recovery-compatible evidence based practices. *Mental Health Weekly,* November 5, p. 5

Anthony, W. A., Cohen, M. R., Farkas, M., & Gagne, C. (2002). *Psychiatric rehabilitation*. Boston, MA: Center for Psychiatric Rehabilitation.

Anthony, W. A., Rogers, E. S., & Farkas, M. (2003). Evidence based practice in mental health. *Community Mental Health Journal, 39,* 101–114.

Beale, V. & Lambric, T. (1995). *The recovery concept: Implementation in the mental health system* (Report by the Community Support Program Advisory Committee). Columbus, OH: Ohio Department of Mental Health.

Beard, J. H., Propst, R. N., & Malamud, T. J. (1982). The Fountain House model of psychiatric rehabilitation. *Psychosocial Rehabilitation Journal, 5*(1), 47–53.

Becker, D. R., Drake, R. E., Farabaugh, A., & Bond, G. R. (1996). Job preferences of clients with severe psychiatric disorders participating in supported employment programs. *Psychiatric Services, 47*(11), 1223–1226.

Bell, M. & Lysaker, P. (1996). Levels of expectation for work activity in schizophrenia: Clinical and rehabilitation outcomes. *Psychiatric Rehabilitation Journal, 19*(3), 71–76.

Blackwell, B., Eiders, K., & Robinson, D. (2000). The consumer's role in assessing quality. In G. Stricker & W. Troy (Eds.), *Handbook of quality management in behavioral health: Issues in the practice of psychology*.

Bond, G. R., Becker, D. R., Drake, R. E., Rapp, C. A., Meisler, N., Lehman, A. F., Bell, M. D., & Blyler, C. R. (2001). Implementing supported employment as an evidence-based practice. *Psychiatric Services*, *52*(3), 313–322.

Campbell, J. & Schraiber, R. (1989). *In pursuit of wellness: The well-being project: Mental health clients speak for themselves*. Sacramento, CA: California Department of Mental Health.

Carling, P. J. (1995). *Return to community: Building support systems for people with psychiatric disabilities*, New York: The Guilford Press.

Davidson, L. & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology, 65*(2), 131–145.

Deegan, P. E. (1990). Spirit breaking: When the helping professions hurt. *Humanistic Psychologist*, *18*(3), 301–313.

Deegan, P. E. (1993). Recovering our sense of value after being labeled. *Journal of Psychosocial Nursing and Mental Health*, *31*(4), 7–11.

Drake, R. E., Goldman, H. H., Leff, H. S., Lehman, A. F., Dixon, L., Mueser, K. T., & Torrey, W. C. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services*, *52*(2), 179–182.

Farkas, M. D., Anthony, W. A., & Cohen, M. R. (1989). An overview of psychiatric rehabilitation: The approach and its programs. In M. D. Farkas & W. A. Anthony (Eds.), *Psychiatric programs: Putting theory into practice*. Baltimore, MD: Johns Hopkins University Press.

Farkas, M., Cohen, M., & Nemec, P. (1988) Psychiatric rehabilitation programs: Putting concepts into practice. *Community Mental Health Journal, 24*(1), 7–21.

Farkas, M., Gagne, C., & Anthony, W. A. (2001). Recovery and rehabilitation: A paradigm for the new millennium. *La rehabilitacio psicosocial integral a la comunitat i amb la communitat, 1*(7/8), 13–16.

Fisher, D. & Ahern, L. (1999, Spring). People can recover from mental illness. *National Empowerment Center Newsletter*, 8–9. Lawrence, MA.

Frese, F. J., Stanley, J., Kress, K., & Vogel-Scibilia, S. (2001). Integrating evidence-based practices and the recovery model. *Psychiatric Services, 52*(11), 1462–1468.

Glisson, C., & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect, 22*(5), 401–421.

Harding, C. M. (in press). Overcoming the persistent resistance of clinicians to ideas of recovery in serious mental illness. In P. Ridgway & P. Deegan (Eds.), *Deepening the mental health recovery paradigm: Defining implications for practice*. Lawrence, Kansas: University of Kansas Press.

Harding, C., & Zahniser, J. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatrica Scandinavica Supplementum, 90*(Suppl 384), 140–146.

Institute of Medicine Committee on Quality of Health Care in America (2001). *Crossing the Quality Chasm: A new Health System for the 21st Century*. Washington, DC: National Academies Press.

Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal, 23*(4), 333–341.

Jacobson, N., & Greenley, D. (2001). A conceptual model and explication. *Psychiatric Services, 52*(4), 482–485.

Kramer, P. J., & Gagne, C. A. (1997). Barriers to recovery and empowerment for people with psychiatric disabilities. In L. Spaniol, C. Gagne, & M. Koehler (Eds.), *The psychological and social aspects of psychiatric disability*. Boston, MA: Center for Psychiatric Rehabilitation.

Lapsley, H., Waimarie Nikora, L., & Black, R. (2002). Kia Mauri Tau! Narratives of Recovery from Disabling Mental Health Problems. University of Waikato Mental Health Narratives Project.

Majumder, R. K., Walls, R. T., & Fullmer, S. L. (1998). Rehabilitation client involvement in employment decisions. *Rehabilitation Counseling Bulletin*, *42*(2), 162–173.

Mayer, R., & Schoorman, I. (1992). Predicting participation and production outcomes through a two dimensional model of organizational commitment. *Academy of Management Journal, 35,* 671–684.

McQuillan, B. (1994). My life with schizophrenia. In L. Spaniol & M. Koehler (Eds.), *The experience of recovery*. Boston, MA: Center for Psychiatric Rehabilitation.

Mead, S., & Copeland M. E. (2000). What recovery means to us: Consumers' perspective. *Community Mental Health Journal*, *36*(3), 315–328.

Pyke, J., Lancaster, J., & Pritchard, J. (1997). Training for partnership. *Psychiatric Rehabilitation Journal*, *21*(1), 64–66.

Ralph, R. O., Lambric, T. M., & Steele, R. B. (1996). Recovery Issues in a consumer developed evaluation of the mental health system. Presentation at *6th Annual Mental Health Services Research and Evaluation Conference*, Arlington, VA, February, pp.1–13.

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

Sanderson, W. C. (2002). Comment on Hansen et al: Would the results be the same if patients were receiving an evidence-based treatment? *Clinical Psychology Science and Practice, 9*(3): 350–352.

Spaniol, L., Gagne, C., & Koehler, M. (1999). Recovery from serious mental illness: What it is and how to support people in their recovery. In R. P. Marinelli & A. E. Dell Orto (Eds.), *The psychological and social impact of disability* (4th ed.). New York: Springer Publishing.

Spaniol, L., & Gagne, C., et al. (2003). The recovery framework in rehabilitation: Concepts and practices from the field of serious mental illness. Sourcebook of rehabilitation and mental health services. J. R. Finch and D. Moxley. New York, Plenum. pp. 37–50.

Spaniol, L., Wewiorsky, N., Gagne, C., & Anthony, W. A. (2002). The process of recovery from schizophrenia. *International Review of psychiatry, 14*, 327–336.

State of Wisconsin Blue Ribbon Commission on Mental Health (1997). [On-line], Available: http://www.dhfs.state.wi.us/MH_BCMH/bluerib.htm.

Sullivan, W. P. (1994). A long and winding road: The process of recovery from severe mental illness. *Innovations and Research*, *3*(3), 19–27.
The Presidents New Freedom Commission on Mental Health (2003). Achieving the Promise: Transforming Mental Health Care in America. Final Report.
Torgalsboen, A. K., & B. R. Rund (1998). Full recovery from schizophrenia in the long term: A ten-year follow-up of eight former schizophrenic patients. *Psychiatry: Interpersonal and Biological Processes, 61*(1), 20–34.
Torrey, W. C., Drake, R. E., Dixon, L., Burns, B. J., Flynn, L., Rush, A. J., Clark, R. E., & Klatzker, D. (2001). Implementing evidence-based practices for persons with severe mental illnesses. *Psychiatric Services*, *52*(1), 45–50.
Unzincker, R. (1989). On my own: A personal journey through madness and re-emergence. *Psychosocial Rehabilitation Journal*, *13*(1), 71–77.
Weingarten, R. (1994). The ongoing process of recovery. *Psychiatry*, *57*, 369–375.
Young, S. L., & Ensing, D. S. (1999). Exploring recovery from the perspective of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, *22*(3), 219–231.