



Recovery

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Presenter

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Welcome & Introduction

Lynn Aronson

Good morning or good afternoon everyone, depending upon where you are, and welcome to today's teleconference. Today our topic is recovery. My name is Lynn Aronson, and I'm from Advocates for Human Potential in Albany, New York. And along with our colleagues at Policy Research Associates we provide technical assistance for the PATH Program. I'll be your moderator for today's presentation. Today we're delighted to have with us Dr. William Anthony. Dr. Anthony is currently the director of Boston University Center for Psychiatric Rehabilitation and a professor at Sargent College of Health and Rehabilitation Sciences at Boston University.

We are sure that today will be a most informative and helpful call to those of you who want to know more about recovery. The presentation today will be divided into 20-minute segments. And after each segment we will have questions and answers. Now let me introduce our featured presenter. In addition to being the director of Boston University Center for Psychiatric Rehabilitation and a professor at Sargent College of Health and Rehabilitation Sciences at Boston University, Bill has authored 100 articles in professional journals, 14 textbooks, and several dozen book chapters. The majority of these publications are on psychiatric rehabilitation. For the past 35 years he's worked in various roles in the field of psych rehab and has been honored for his performance as a researcher, an educator, and a clinician.

He is currently co-editor of the Psychiatric Rehabilitation Journal. Along with David Shern and Sam Tsemberis, he's conducted a randomized clinical trial of psychiatric rehabilitation approach for people who were homeless and street dwelling and severely mentally ill. And this can be found in the American Journal of Public Health December 2000. I'd now like to turn the call over to Bill and welcome him and say thank you for being our presenter today.

William Anthony

Thank you very much. We're going to talk about recovery today, the vision of recovery and the whole field of severe mental illnesses. And on your first slide it should say, "The Need for a Vision and Characteristics of a Vision." So let's start right off with the first slide.

The Need for a Vision

Ten years ago I made the comment that there is a revolution brewing in the field of mental health. And I wasn't talking about a revolution in managed care or the development of MRIs or anything like that. I was talking about a revolution in vision about what was possible in this field. And of course that revolution and vision was the whole concept of recovery.

In the past century we really didn't talk about recovery. Matter of fact if some of you read the Diagnostic and Statistical Manual of the American Psychiatric Association regularly you would have found things that said severe mental illness or schizophrenia was characterized by acute exacerbations characterized by increasing deterioration between symptoms. In other words, you weren't getting better if you had that diagnosis, and there was certainly no talk of recovery.

Our whole system and programs and practices were based on the assumption that [with] severe mental illness you deteriorated over time. That has certainly changed now but at that point we also had no consumer-based vision of what was possible in this field. We really talked about concepts such as continuity of care, comprehensive services, community support systems, and they're all well and good but they weren't really a vision that was consumer-based.

In response to the question, "Well what do you want most out of life?" I've never heard the consumer say I want continuity of care. Obviously there's nothing wrong with continuity of care or comprehensive of services or community support systems but they weren't the vision of the system.

Now I think we have a vision, and vision is so important in the field. I can't underestimate it or I can't overestimate it. When you think of other places that have had visions that we recall, the National Cancer Institute wants to cure cancer in our lifetime. That's a great vision that speaks to the consumer. NASA had a vision: put a man on the moon in this decade, albeit a sexist vision but it was a vision. Now they don't have a vision, and they're not doing too well either.

So a vision is something that pulls us into the future. The recovery vision pulls us into the future as well. It guides our story that we continue to unfold in the field of mental health. I think it changes the whole paradigm of what we think is possible when we look through the lens of recovery. Our assumptions and our values change. And this is how science changes, with the whole paradigm.

I always use the example of at one time the earth was flat, and now we think it's round. And when we learned about that, it changed all of our assumptions. It changed what we talked about. I mean it used to be that we talked about what would happen when we fell off the end of the earth? What were the monsters like down there? Were they dragons, etcetera?

Now the questions are different. You know, we're talking about questions and naval power and things like that. The whole culture has changed because the paradigm changes. And that's what is happening in the field of severe mental illnesses.

Evidence for Recovery

Let's go to the next slide, and that slide should say, "Evidence for Recovery from Severe Mental Illnesses." We do have an evidence base now for recovery. It is in two places I think, and one is anecdotal evidence—the writings of people with severe mental illnesses. They've talked about their own recovery, their own healing, and their own growth.

That has alerted the field to the fact that recovery can happen. The message is a consumer message. Those

of us who are professionals who deliver it are just the messengers. And I don't like that term so well because you know what they do to messengers. Someone told me they shoot them.

But at any rate, we are the messengers of what consumers are doing and writing about, which is recovery. I think the second piece of the evidence is all of the international studies that have been done on long-term outcomes of severe mental illnesses. And for the most part those studies have found that the majority or close to a majority of people with severe mental illnesses does in fact recover, so that there is both empirical evidence and anecdotal evidence to the fact that recovery is happening.

Now what I want you to do is turn to the next slide which says, "Recovery Defined." People are talking about healing, growth development. This happens to be one definition of recovery that I wrote back in the early 1990s, the development of new meaning and purpose in one's life as one grows beyond the catastrophe of mental illness.

The essence of that definition is that people get on with their life after being diagnosed with one of the severe mental illnesses, and their life becomes meaningful and purposeful again. There are all sorts of definitions. My job today is not to review those definitions but to mention that they're based on anecdotal and empirical evidence.

Recovery Is Universal

Look at the next slide, and it should say, "Recovery from Catastrophe is a Universal Experience." Recovery from severe mental illnesses is best understood when we just talk about recovery from any catastrophe.

I want you to think of your own personal catastrophe in your life. Now if you've lived a life you've had catastrophes. You've had death of a loved one. You've had divorce, rejections, financial ruin. I hate to go through all of the possible catastrophes there are. But most of us have had catastrophes in our life. And in order to understand recovery from severe mental

illnesses, I want you to think of a catastrophe in your life that you have had, not a mental illness catastrophe.

As you were going through this catastrophe, what did you feel like? What were some of the feelings that you were experiencing as this catastrophe was unfolding and you were trying to get through it? And second, what helped you recover from this personal catastrophe? As you were recovering and as you were getting back and healing and developing meaning and purpose in your life again and feeling in charge, what were some of the things that helped you to recover from this, as I say, non-mental illness catastrophe?

I think the first question is answered by just a feeling or a word or a couple of words, how you're feeling. And the second question is answered by maybe a phrase, maybe just a word in terms of what helped you recover from your own personal catastrophe.

I want to get some examples, and then we'll work with them and see what recovery is and how recovery is a universal experience and how we can learn from this universal experience of recovery from catastrophe some of the important things in recovering from a catastrophe due to a mental illness.

So right now you should have thought about what did it feel like and what helped you recover from a personal catastrophe. I'll talk about some of the answers that people sent to me beforehand.

Lynn Aronson

Great.

William Anthony

In the emails that I got, people said while they're going through a catastrophe they felt confused, alone, little interest or empathy, couldn't enjoy things, pain, self-doubt, confusion, helplessness, hopelessness. Those are some of the feelings that were expressed about when they're going through a catastrophe.

Now I've done this exercise and with a lot of other people as well and not over a phone line, but in person. And in some of the feelings you hear are confusion, anxiety, depression, feeling not in touch,

overwhelmed. These are some of the feelings that I hear as people talk about non-mental illness catastrophes. And if we think about that and think about the fact that if you were diagnosed with mental illness and those feelings were expressed of confusion and helplessness and depression, etcetera what would happen to those feelings?

Lynn Aronson

Bill, before you go on to talk about what would happen, I do have a couple of more that some folks just emailed us. Some of them are the same as yours: overwhelmed, scared, and raw in the beginning, betrayed and cheated.

William Anthony

So, betrayed, cheated—you might even think some of that might be paranoia. But at any rate, if it's a non-mental illness catastrophe we think of those feelings as natural in the recovery process. Whereas if you're a person with mental illness, what happens is those often get diagnosed as symptoms.

When you put a recovery lens over your eyes and look at things with a recovery focus it's not so simple. It's not so simple to just label people with symptoms because that may be part of the natural healing process. So I'll leave it at that, and you can think of the implications for your own practice. But it's not as simple as just labeling people as symptomatic because these may be feelings that are the first stages of recovery.

In terms of the second question, Lynn, why don't you put out what you have and then I'll add to that.

Lynn Aronson

Okay. Some of the things that help folks have said are talking it through, friends help, good support, insight, faith, hope, tenacity. Support from family and friends, meaningful roles such as parenting, working, and having a socially acceptable practice by which to recover.

William Anthony

Okay. And let me add to those things I got before the talk: compassionate friends and families; people that give me space; people that know what I'm going through; support of friends, family, and employer; time itself, just the passage of time.

Lynn Aronson

Another answer was being involved in my faith helped a lot.

William Anthony

All right. Family, friends, peers, support, time. Those are some of the examples.

Lynn Aronson

Here let me just do this one because I don't think we said this one. What helped in the recovery was humor, watching some good stand-up comedy. It's also important to ask for help and to tell people to come by and visit and to share their humor with them.

William Anthony

Okay, all right. If you listen to what people say in terms of support from family, friends, faith, time, humor, a job, and a role, notice how many of those things are not mental health things. They're not necessarily medication, psychotherapy, professional counseling. Now please don't say that Bill Anthony said none of those things are important. That's not what I'm saying.

When you put on the recovery lens, when you broaden your perspective from just alleviating discomfort to recovery and meaning and purpose and getting on with life and so forth, notice how there are so many non-mental health things that are mentioned. And those things are important also when you're recovering from severe mental illness.

So what I've tried to do with this little experience is to give you an understanding of what recovery feels like in the fact that you have also experienced recovery. And so sometimes it's good to get in touch with your own recovery to get a better understanding of what

people with mental illnesses are going through and what they might need in their own recovery.

Now I could also take a few questions.

Discussion

Caller

I didn't really have a specific question. I just wanted to reiterate the things that were said based on recovery and talk about the WRAP (Wellness Recovery Action Plan) plan and all that, and I didn't know if you were going to bring those things up. Because even if it's not mental health related I think those things are important that you have some sort of recovery plan in place, and I think that you can incorporate some of the mental health recovery plans into the universal recovery experience.

William Anthony

I think that's a good point. I think—I didn't try and make it specific to mental health but I didn't give that direction very well in the slides. But at any rate, I think planning, an example being WRAP planning, is something that people mention about recovery from any catastrophe. They plan their [way] out of it, they took steps, they anticipated some things so that planning was and is an important part of recovery from any catastrophe. The WRAP plan is an example of a technology in mental health that can be used.

Caller

Right, right. That's all I wanted to do. WRAP is what we use here, and I know there are other plans as well. And I think that peer support is far and away the best way to work with that.

William Anthony

Peers and friends and people who have been through the experience—those are always mentioned no matter what catastrophe you're talking about. Peer support would be an example of that in the mental health field of recovery.

Caller

Yes, I'm a consumer, and I've worked very hard to achieve recovery over a period of 40-50 years, and I feel that I have achieved a rather high level of recovery. But there's something that is bothering me so much. I would like an answer. Why was I able to do it? Why and why are there others who can't or won't?

I almost feel guilty over what I have achieved when I see other people who have stood still or not achieved very much. I know that you can't achieve a great deal of recovery if a patient floats in and out of therapy, goes on and off medication. Then I feel well it's understandable that you don't achieve much.

But why are there other people who are in programs who are trying? Why does the fact that I've recovered mean that I had a higher degree of wellness than they did? Does it mean that I was less sick than they are?

William Anthony

Boy you ask a million dollar question, don't you, in terms of the why. And the interesting point is that we cannot predict who is going to recover and who isn't, so that shows you that we don't really know the why of it. We might find that the people who did a little better before they became severely mentally ill might have a better chance of recovering.

But I hesitate to get into those specifics because we don't know that much, and it's better to say we don't know. We try to help and facilitate everyone's recovery, and we hold that out as a goal for our whole system.

But certainly don't make people feel guilty either for the fact that they have recovered or the fact that they haven't because there's so much more to be learned.

Caller

Okay, thank you.

Lynn Aronson

That leads right into a question that we've gotten over the Internet: "What are some of the things that might

prevent a person from going through the recovery process?"

William Anthony

I have some ideas. Let me hold that until the next slide because we're talking a lot about that in the next slide. If you go to the next slide it says, "Recovery Assumptions" and you should have a list of things on that particular slide, and I want to talk about some of them. And I think the flip side of some of these is what prevents you and me and everyone else from recovering from a catastrophe.

Recovery Assumptions

We have learned over and over again is that recovery can occur without any type of professional intervention, that professionals don't hold the key to recovery. It's the individual that does. The task of professionals is just to facilitate the recovery process but can't take it over because it's the task of the individual to do the hard work of recovery.

Recovery is promoted by professionals certainly but also by self-help groups, families, and friends. You noticed in the comments of what was helpful to you what always comes up first is family, friends, peers, support, etcetera.

And that comes up and is mentioned way more than professionals. But professionals play an important role. It's just that we also have to be aware of the fact that you don't need a professional necessarily. Hopefully professionals will be helpful.

Non-mental activities and organizations, you know, sports, clubs, adult education, churches, all of these are helpful in developing a person's path to recovery. So we have to make sure that we hold very important these non-mental activities and non-mental health professionals in helping bring about recovery.

The second one is the importance of relationships. A common denominator of recovery is the presence of people who believe in and stand by the person in need

of recovery. What often happens for people that don't recover is that there isn't a person around.

There isn't that person present; the person that believes in them when they don't even believe in themselves and that affirms their personhood, that person will always be there. I think the relationship is [crucial]. And sometimes it's not appreciated at the time. It's appreciated after one starts to recover, and they, say, "Wow, I never would have made it if so and so hadn't been there for me." So I think that is a very important part of recovery.

In terms of the next point on the slide it says, "Causes of Severe Mental Illness." A person's recovery is not related to the cause of the mental illness. We don't debate this as much as we used to.

There used to be two camps. One was the biological that felt that mental illness was biological, and some people thought it was psychosocial, and some people think it's both. It's controversial at times to get involved in those discussions. But the recovery point is that it doesn't really matter.

You can recover whether your severe mental illness was biologically caused or psychosocially caused or both. And when you think about other illnesses that are definitively biological like blindness or something like that, well you can recover from blindness. You can develop meaning and purpose in your life even though the illness is biological, even though the impairment is unchanged or may even worsen. You can still recover, which I think probably gets us to the next point.

The fourth point on that slide, we're on symptom reoccurrence. What we've learned is that recovery can occur even though symptoms recur. Severe mental illnesses are often episodic—exacerbations occur and sometimes they occur from nowhere. They just occur. But that doesn't mean somebody isn't recovering. You can experience intense psychiatric symptoms episodically but still be on the road to recovery, and of course the opposite occurs. You can recover and not experience any symptomology again.

Just because you might experience symptoms doesn't mean you're not starting to develop meaning and purpose in your life and growing beyond the catastrophe of mental illness. I think that recovery does change over the frequency and duration of symptoms. And that's just, as I say, an observation—observing colleagues and friends and clients and so forth—but I think sometimes the intensity of the symptom is still there.

As some people have said to me who are recovering and having exacerbation, and this is a quote, "I was as crazy as I ever was." But the duration was less and the frequency was less. In other words it didn't happen as often over a period of years and, when it did happen, it didn't happen for as long a period. If they're moving along in their recovery they seem to rebound quicker from those symptoms. Now I caution you. This is just all my observations there. I don't know if anybody has ever studied that. I certainly haven't read it. I do know that you can recover even though symptoms recur. And you can get measures of recovery that show improvement even though there are symptoms but this last part about the frequency and duration of symptoms is kind of a personal observation.

If we look at the next point on the slide, there are many paths to recovery. We hear this over and over again as we listen to people's stories and read their stories and experience recovery ourselves from our personal catastrophes. Everybody has a unique story. So we can't really do a recovery from several mental illnesses by the numbers, if you will.

There is great variability. That's what makes it so interesting and so miraculous. But everybody goes about it a little bit differently, and when we ask what was helpful, people came up with different things. And when we asked you about how you felt people came up with different things about how they were feeling during the process. So there are many paths to recovery.

Number six on there, the importance of choice. Choice is critical, you know it. And when you recover you reach a point where you start to become that captain of your own ship again. You start to feel like you're in charge, that there are opportunities that you want

to figure out what to do, and it's your choice. We just find that the opportunity to choose is more critical than what is first chosen.

In other words, it's not so much what you choose first because you're probably going to choose something different the next day or the following day. But it's a fact that you chose whether it's choosing to get up out of bed or choosing to go for a job interview or choosing to talk to somebody. You're feeling like it's my choice.

I remember that one of people that we were helping here at Boston University was kind of "hippyish," you know, long hair and the clothes, yet he was an expert in Russian. So he thought he would interview for the CIA and that he was going to work for the CIA. Well, I ran into him on the street one early morning as he was coming back to the center after an interview the day before, and he said, "Well, I just changed my choice."

And he'd been to the interview, and even though he was perfect in Russian, they just didn't seem to think he was the right person. But he was so pleased with himself that he chosen something and tried something out, and now he said, "I'm coming back to the center to choose something else." So he was deep into the choice process and feeling powerful because he was choosing again.

The last point is the consequences of mental illnesses. Recovery from the consequences of the illness is sometimes different than recovering from the illness itself. The people with severe mental illnesses talk about discrimination, prejudice, poverty, the effect of not being able to perform valued roles in society as a parent or a worker, a student, etcetera.

And those seem to be more difficult to recover from than the symptoms. That's what I mean by the illness and then the symptoms of the illness being as difficult and, in some cases, more difficult.

So that we've had to learn to pay attention to the consequences of the illness, unlike what we did years ago where we just focused all our attention on the illness and assumed that either the consequences

weren't there or they weren't that important. So recovery from the consequence of the mental illness is something we learned from people's recovery stories and when we put a recovery lens on our eyes.

Recovery: Vision or Outcome

So let's flip to the next slide. It says, "Is Recovery a Vision, Process or an Outcome?" I talked about recovery as a vision, something that guides the whole system because it guides our whole organization. We need to be thinking about recovery to pull us into the future as a vision.

But it's also a process. Are there principles? Are there phases? Well, qualitative research is trying to understand that by interviewing and talking with people who are going through the recovery process. A colleague of mine, LeRoy Spaniol, says well, he can pretty well tell when people are in for different phases of the process, but it's not necessarily linear and it can be cyclical.

But he talks about different phases and, again, he talks about them because he's interviewed hundred of people in recovery or who are trying to recover. He says one phase is when you're [so] overwhelmed with the disability that your whole life is just submerged in the fact that you have this severe mental illness, and there is not much else to your life. He said another phase is struggling with the disability when you're trying to get your head above water and trying to make some changes in your life.

And then he says another phase is living with the disability where you're actually managing the illness fairly well, and it's still a big part of your life but you're also getting on with your life.

And then he talks about another phase of living beyond the disability when really the disability, the illness, is no longer really anything that defines you and your activities and you're really living beyond that. So we know a little about the process, and that may get back to the question that was asked before on the why. You know, we don't know that much about the process.

Well, what about the outcomes? We've learned that the outcomes have to go way beyond symptom relief or recidivism or relapse. If you're talking recovery, you're talking outcomes—about roles, living, learning, working, social roles in the natural community—talking about being successful and satisfied in those roles. You're also talking about psychological indicators of self-concept or self-esteem or well-being. Those are the things that people talk about when they talk about recovery. It's not just symptoms.

So recovery is a vision, a process, and an outcome. All right, 20 more minutes are up so I am going to ask Lynn to open it up for questions.

Discussion

Caller

I have suffered schizophrenia since the age of 16, and I wanted to say I thought you were very enlightening when you spoke today. I have a social worker here, and they're all trying to get me through to my recovery and I want to thank you again for a wonderful program today. And I'm sure that everybody in this whole group was very enlightened.

William Anthony

I appreciate the kind comments. Not only do you have to get rid of the symptoms, you've got to deal with all of these consequences that are as harrowing sometimes as the symptoms, so thanks for your comments.

Caller

Thank you.

Lynn Aronson

Our next question.

Caller

I had a question about recovery and the assumptions. One of the things that I didn't really hear mentioned or talked about a lot was how homelessness and the

lack of a stable life environment can affect mental illness and the overall function of anybody, even somebody who is not mentally ill if they are found to be homeless.

William Anthony

That's an excellent comment. I was alluding to that when I talked about the consequences of mental illness, and if you're dealing with homelessness, it's very difficult to recover if you're dealing with those consequences. Those are sometimes more difficult to recover from than the illness. I used to comment that sometimes when people are homeless we give them a case manager. What they really need is a home.

Caller

Exactly.

William Anthony

So, you know, we sometimes think in mental health terms, you know, case management, treatment, and let's get them a psychiatrist or let's make them be on their medication or be in a home where we don't think about the home first. And that's certainly what I would advise when it comes to recovery. The home itself can do a great job in alleviating symptoms and discomfort and helping people become functional.

So I think you folks are right on track with your focus on getting the person housing, a home, and the supports that are needed to do that. You know, to me it would probably help people's recovery more than other mental health interventions, but I'm not going to go there. But certainly a home and home support are critical to recovery.

Caller

Okay, thank you.

Lynn Aronson

You may ask your question.

Caller

I suffer from bipolar. My daughter passed away a while ago, and I'm just wondering: I need to grieve and I can't grieve. And that's what I'm wondering.

William Anthony

I can't speak specifically to your instance but let me speak to something that may be useful. The death of a daughter is certainly enough to make any one of us depressed. So medication can help that. I guess what I'm saying is when you have these catastrophic experiences and you have symptoms related to them, some are normal parts of a recovery.

But if the medication can help you get through the next day and the next day and the next day, that's great. But there are reasons for that depression, and there are people that have had that same catastrophe and eventually gotten through it with people, with medications, but understanding that these strong symptoms speaks to going through a negative situation.

Lynn Aronson

Bill, I'm going to interrupt you just a second with a couple of email questions that have come in. There's a question, and she wants to know if there are examples when someone is suffering and should not have choices, for instance, taking meds or attending professional sessions especially for persons who are homeless and need to get and keep housing?

William Anthony

That's a great question. I think I tend to err on the side of trying to make sure people get choices, in other words, to maximize the opportunities for choice. I mean this is most apparent in a forensic system where choice is taken away. We try and work in forensic systems to give people choice within that system. So that's a difficult question, and of course you've wrestled with it yourself.

The principle should be how we can get the person to the point where they're making choices and

we're allowing that dignity to risk and so forth. Our tendency has been to err on the other way.

I would say sit down and take some real effort to figure out if there can be choice, if risk can be minimized, and you're probably doing this. So forgive the lecture. But all I'm saying is the principle always has to be how we can maximize choice.

Lynn Aronson

Thank you. Another one that came in over the Internet is, "How can we help our peers who have been long-term consumers of mental health services make the shift from focusing on the illness, diagnosis, and medication to focusing on recovery?"

William Anthony

That's a good question. We try and move people into roles other than patient roles. And, you know, can you move people in the student role or worker role and away from that patient role that people have really learned how to live in? It gets back to the step-by-step planning.

I'm reminded of one person who said to me, "I've been a patient for a long time and they paid me well for it." Obviously they didn't pay him well for it, but he was on Social Security. And he says, "Now I've got to think about a student and a worker, and it's very scary."

So I think to try and understand people who have been in that patient role for so long and who have been encouraged to stay in that patient role with all sorts of incentives and system barriers. We have to work on other roles they may wish to choose and help them choose that role because it's hard to give up the patient role when there's no other role.

Lynn Aronson

Okay, then I think we're just about on time, Bill, to finish up with your last segment.

Recovery and Evidence-Based Practices

William Anthony

Okay, all right. If we can go to the last slide that says, “Recovery and Evidence-Based Practices.” I mentioned evidence-based practices because it’s obviously sweeping the country. And there are a couple of comments I want to make about that.

First of all it’s an important concept, an important direction. I mean who amongst us would not want to go to a healthcare professional and have them use the best evidence-based practices.

But I’ve been critical of the implementation of evidence-based practices, and let me be clear about this because I get criticized all the time. Please, the concept, the direction is a good one. I don’t think there’ll be any turning back from that concept. But I think in mental health we’ve been a little premature in its implementation and I’m going to give you a couple of reasons why. Feel free to question and disagree with me on the question and answer period.

I wrote early on when those concepts came out that there was little evidence as to what in randomized clinical trials produces recovery. I just don’t think we know that much. I think we know more from the qualitative research than we know from the randomized clinical trials. And I said a lot of these evidence-based practices were conceived before the concept of recovery was even well known and sometimes implemented before that. But at any rate I think right now the evidence-based practices help us to avoid relapses, to avoid hospitalizations.

We are certainly able now to get people, unfortunately, dead-end jobs but jobs, and that’s a step above where we were before, believe me. We have to make a realistic assessment of where we are. These things are far from recovery outcomes of self-esteem, of self-concept, of well-being, of being successful and satisfied in our job and our living situation, and stuff like that. So I don’t think we have the data to suggest what interventions really bring about recovery.

Some other caveats I would mention about evidence-based practices. I know your particular field in homelessness is being influenced by that. And sometimes the evidence-based practice drives the solution rather than the problem.

Sometimes we see the solution, and that’s why we need more evidence-based practices implemented when people are recovering or people are without homes. And maybe the evidence-based practices we have right now aren’t very good at getting those things.

So I worry that sometimes it’s talked about as a solution, and it’s not tied into the actual problem. I worry that sometimes we get all enamored with doing something right and adhering to fidelity rather than doing the right thing. I mean there are differences in those so it’s just a worry. I think the focus should be on the process, the evidence-based processes.

Seems to me there’s a lot of data about how people change, and I don’t mean people with mental illnesses but people. This data on how people change would apply to people with mental illnesses and how they change in the presence of a positive relationship. They change when they’re allowed to set their own goals. They change when they’re taught skills. They change when they receive supports. They change when they have hope.

This is the direction I would go in developing interventions that have relationships, goal-setting, skill-building that build hope, that have supports. That’s where the evidence is around the process.

Another caveat I would have is that sometimes we focus on the outcomes produced rather than the outcomes desired. Now we can produce certain outcomes so we continue to prove these even though the people are telling us they want other outcomes.

Another caveat is sometimes I think we get started and we start talking about the researchers’ vision rather than the people’s vision. We also emphasize data over values. What’s the data say rather than what are the values?

Recovery and Values-Based Practices

So these are just some caveats, and let me just say that I like the concept. I like the direction. The implementation as it's playing out worries me. We emphasize data over values, which is my next point, that there is recovery and value-based practices. Value-based practices to me is a just a term I coined to say that any practice, whether it's evidence-based or not, should be based on recovery values.

And we really need to make sure that whatever practice we're implementing is also value based. And when I say that practice should be based on recovery values I mean it should reflect the values of things like personhood and choice and growth and personal involvement. The practices need to incorporate those values.

And if you look at some of the major changes in the last 30 years in this field, some of them were ACT (Assertive Community Treatment), supported employment, and consumer-operated services. I mean these are three big innovations if you look back over the last 30 years. And you say, "Well, how did they happen?" And they didn't happen because there was any data. That's the interesting part.

Judy Chamberlain wrote her first book on her own years and years ago because of a value she had that most other people didn't have but she was able to propagate the value that consumers could be helpful to one another and that was a value. As for ACT, they had a strong value and a passion that people did not have to be in institutions to receive services.

But they didn't have a whole lot of data. They made that innovation based on their values.

And then you look at supported employment. That concept developed out of Madeline Will and [her work on] supported employment for people with development disabilities. She said, essentially, I don't want my son who is developmentally disabled and going to be getting out of school to be in a sheltered workshop. I think we need some other alternatives,

and supported employment was developed in that area first.

But these innovations were based on people who had different values. There wasn't a whole lot of data. So I guess I'm pushing the fact that whatever the intervention, have these recovery-based values as a part of it.

Well, line up your policies, your procedures, your staffing, your staff selection, your documentation and your records. Line them up and run them through these recovery values. Are people with disabilities helping to select the staff? In policies, do we have a policy in our housing program that says people have to be evaluated by a psychiatrist before they get a home? Well, how does that affect choice? You know, is that really a value that reflects choice?

So you can just line up your organization's policies and procedures, by staffing and documentation, and see if all of these things reflect some of these recovery values. I suggest you work towards more and more of these things reflecting recovery values. And it's an effort. Engage the people with the disabilities to help you. They will; they're very perceptive about whether this particular procedure or setting or environment or whatever reflects recovery values or whether it does not.

So I would suggest that outcomes can probably be improved if you inculcate these recovery values in your organization and into your system. But our whole system was designed to prevent deterioration and to try and maintain people, either in the hospital or the community. So we have a system that was designed not for recovery so there's got to be some major changes. The implications for system planning are just immense.

Future Directions

In terms of the last slide and in terms of review and future directions, I talked about recovery as a new vision and how different it is from the old vision, that the old vision of deterioration is so divergent from

the vision of recovery. Well, I think this changes everything.

I tried to give people an experience of what recovery is rather than the definition although I did give one definition based on some things we did at CMHS. We didn't really come up with a definition but we came up with some principles, some assumptions, and some values and so forth.

Those are what you need to get in touch with based on your own experience of recovery. When you put the recovery lens over your eyes, there are new assumptions and there are new values.

In terms of the future, the system has to develop policies and procedures, based on recovery values. What's the basic principle? What's the basic value? Where do you begin?

If we could just get to the point where we're treating people with severe psychiatric disabilities as people first, that would be a tremendous breakthrough. If we looked at the data that suggested how people change, how do we help people?

And we looked at things like when they set their own goals and when they have a positive relationship, when they're taught skills, and when they receive support, and then we build in hope. I think that's a place to begin, and I really think we need to do this.

This new vision that we're experiencing is a tremendous opportunity. It breathes life into our system and hope and maybe energy.

I'm going to close with a quote from Thomas Edison who had nothing to say about recovery from severe mental illnesses obviously. But he did have a lot to say. And one of the things he said is that the reason people don't recognize opportunity when it comes knocking on their door is it's disguised in overalls and dressed as hard work. To get this vision of recovery into the system is certainly hard work. There's no other way than hard work.

I'll close with that. I think we have time for some questions at the end so, Lynn.

Discussion

Lynn Aronson

I did have one additional question that came in by the email. And this one asks, do you feel that there is stigma in mental illness?

William Anthony

Oh absolutely, one of the big consequences of mental illness. I've been swayed by people who don't like that term stigma because it's stigmatizing in itself. I usually talk about prejudice and discrimination and people's attitudes and prejudices. People's outright behavioral discrimination gets in the way of so much that we're trying to accomplish in this field.

So yes, prejudice and discrimination is certainly rampant in this field. And it makes the job of people who are working in the field of homelessness and so forth all the more difficult

Caller

How does recovery work with the rehab option?

William Anthony

How does recovery work? That's a beautiful question. How do we sell Medicaid on the fact that what we're doing is important and should be funded by Medicaid, you know, as a part of that question.

If I'm talking about it just in general without any worry about rules and regulations, it fits in very nicely because one of the outcomes of recovery is role functioning, being able to do tasks and abilities and skills that allow you to function again.

So in terms of the rehab option, it could fit very nicely. But we need to educate the people that write the rules as well as the people who are the helpers that to try and help people within those Medicaid restrictions. There's a lot of education that needs to go on on both sides, both for the Medicaid people and the people

that do the helping so that they are able to show how it does fit.

Conclusion

Lynn Aronson

Thank you. We're just about out of time, and so we'll conclude today's program. I'd like to remind everyone please to complete and return their evaluation form and to visit the PATH Web site at www.pathprogram.samhsa.gov for all of our other resources available to you.

And of course I want to thank Bill, our featured presenter. Please watch for the announcements of future teleconferences that we will be sending out to you on the PATH listserv.

And with that our call is concluded. And thank you all for participating. Thank you, Bill.

William Anthony

Thank you. ■