

A RECOVERY-ORIENTED SERVICE SYSTEM: SETTING SOME SYSTEM LEVEL STANDARDS



WILLIAM A. ANTHONY

WILLIAM A. ANTHONY, PH.D. IS
EXECUTIVE DIRECTOR OF THE CENTER
FOR PSYCHIATRIC REHABILITATION AT
BOSTON UNIVERSITY.

FOR INFORMATION CONTACT THE
AUTHOR AT 940 COMMONWEALTH
AVENUE WEST, BOSTON, MA 02215.
TEL: 617/353-3549;
E-MAIL: wanthony@bu.edu.

In the 1990s a number of state mental health systems, behavioral managed care entities, and county systems of care declared that their service delivery systems were based on the vision of recovery. A recovery vision of service is grounded in the idea that people can recover from mental illness, and that the service delivery system must be constructed based on this knowledge. In the past, mental health systems were based on the belief that people with severe mental illness did not recover, and that the course of their illness was essentially a deteriorative course, or at best a maintenance course. As systems strive to create new initiatives consistent with this new vision of recovery, new system standards are needed to guide the development of recovery oriented mental health systems. Based on research on previous system initiatives and current consensus around accepted recovery practices and principles, a set of system standards that are recovery focused are suggested to guide future system developments.

The 1990s has been called the “decade of recovery” (Anthony, 1991). Two seminal events of the preceding decade paved the way for the concept of recovery from mental illness to take hold in the 1990s. One factor was the writing of consumers (e.g., Anonymous, 1989; Deegan, 1988; Houghton, 1982; Leete, 1989; McDermott, 1990; Unzicker, 1989). For the preceding decades, and culminating in the decade of the 1980s, consumers had been writing about their own and their colleagues’ recovery. The consumer literature suggests that recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of

living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability (Anthony, 1993). Conceptual and empirical studies on the recovery process have begun to appear (Spaniol, Gagne, & Koehler, 1999; in press). Based on the writings of consumers, Table 1 identifies several assumptions about the recovery process that can be used to guide service system development.

In addition to the conceptual work of consumers, the other major factor precipitating the acceptance of the recovery vision was the empirical work of

Harding and her associates, whose research and analytic work initially impacted the field in the 1980s. Over the years Harding (1994) and her colleagues have reviewed a number of long-term research studies, including their own (Harding, Brooks, Ashekaga, Strauss, & Breier, 1987a; 1987b), that suggested that a deteriorating course for severe mental illness is not the norm. "The possible causes of chronicity may be viewed as having less to do with the disorder and more to do with a myriad of environmental and other social factors interacting with the person and the illness" (Harding, Zubin, & Strauss, 1987, p. 483). It was the ongoing analysis of long term outcome studies by Harding and associates that provided the empirical basis for the recovery vision.

In contrast to Harding's research and the emerging consumer literature, throughout most of the 1980s, and officially until the appearance of *DSM III-R*, the belief was that severe mental illness, particularly schizophrenia, was a deteriorative disease (American Psychiatric Association, 1980). This seemingly definitive diagnostic conclusion turned out to be ill-conceived, and inhibited acceptance of the recovery vision. Antithetical to the concept of gradual deterioration due to mental illness over time is the concept of recovering over time from mental illness. Harding's later work (Desisto, Harding, McCormick, Ashikaga, & Brooks, 1995a, 1995b) involved a comparison of the long term outcome of people with psychiatric disabilities in two different states. This masterfully designed, three decade long follow-up examined what might account for system wide differences in consumers' recovery, and once again confirmed, as consumers had been saying, that recovery from mental illness was happening.

Table 1—Assumptions about Recovery

FACTORS / ITEMS	REASONS
1. <i>Recovery can occur without professional intervention.</i>	Professionals do not hold the key to recovery; consumers do. The task of professionals is to facilitate recovery; the task of consumers is to recover. Recovery may be facilitated by the consumer's natural support system.
2. <i>A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.</i>	Seemingly universal in the recovery concept is the notion that critical to one's recovery is a person or persons in whom one can trust to "be there" in times of need.
3. <i>A recovery vision is not a function of one's theory about the causes of mental illness.</i>	Recovery may occur whether one views the illness as biological or not. The key element is understanding that there is hope for the future, rather than understanding the cause in the past.
4. <i>Recovery can occur even though symptoms reoccur.</i>	The episodic nature of severe mental illness does not prevent recovery. As one recovers, symptoms interfere with functioning less often and for briefer periods of time. More of one's life is lived symptom-free.
5. <i>Recovery is a unique process.</i>	There is no one path to recovery, nor one outcome. It is a highly personal process.
6. <i>Recovery demands that a person has choices.</i>	The notion that one has options from which to choose is often more important than the particular option one initially selects.
7. <i>Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself.</i>	These consequences include discrimination, poverty, segregation, stigma, and iatrogenic effects of treatment.

Adapted from Anthony (1993).

SYSTEM PLANNING AND THE RECOVERY VISION

During the 1990s increasing numbers of states and counties adopted a recovery vision as the overriding vision for their system planning. The Community Support System (CSS) perspective as to the critical services needed to be helpful to people with psychiatric disabilities

became a part of the thinking of many system planners and administrators. Most comprehensive mental health system initiatives in the 1980s and 1990s can be traced to the CSS conceptualization of basic services (National Institute of Mental Health, 1987). Anthony (1993) used the CSS model as a basis for describing the essential services of a recovery oriented system. Based on the CSS framework, the Center for

Table 2—Essential Services in a Recovery-Oriented System

SERVICE CATEGORY	DESCRIPTION	CONSUMER OUTCOME
Treatment	Alleviating symptoms and distress	Symptom relief
Crisis intervention	Controlling and resolving critical or dangerous problems	Personal safety assured
Case management	Obtaining the services client needs and wants	Services accessed
Rehabilitation	Developing clients' skills and supports related to clients' goals	Role functioning
Enrichment	Engaging clients in fulfilling and satisfying activities	Self-development
Rights protection	Advocating to uphold one's rights	Equal opportunity
Basic support	Providing the people, places, and things clients need to survive (e.g., shelter, meals, health care)	Personal survival assured
Self-help	Exercising a voice and a choice in one's life	Empowerment
Wellness/prevention	Promoting healthy lifestyles	Health status improved

In Anthony, Cohen, Farkas & Gagne (in press). Adapted from: Cohen, M., Nemec, P., Farkas, M., & Forbess, R. (1988). *Training technology: Case management*. Boston, MA: Center for Psychiatric Rehabilitation.

Psychiatric Rehabilitation has identified the quintessential outcome of each service intervention and the description of the process each service uses to achieve that outcome (Anthony, Cohen, Farkas, & Gagne, (in press). (See Table 2.)

The Boston University Center for Psychiatric Rehabilitation, along with its organizational consultation affiliate, BCPR, is directly aware of recovery initiatives in selected states in which they have been consulting, including such states as California, Iowa, New York, Ohio, and Washington. The Center is

currently collaborating with the National Association of State Mental Health Directors (NASMHPD), the National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA) and the Consumer Organization Networking and Technical Assistance Center (CONTAC) to describe and evaluate the extent to which state mental health systems have implemented policies and practices that promote recovery.

Jacobsen & Curtis (2000) have already examined several states' recovery based

planning, focusing on how states are using specific strategies to work toward a recovery vision. These strategies include: developing recovery vision statements; educating personnel about recovery; increasing the involvement of consumers and family in planning and service delivery; and implementing "user-controlled" services.

RELEVANT SYSTEMS LEVEL RESEARCH

Perhaps the most straightforward definition of a system—and a definition most relevant to today's mental health service system in particular—is that a service system is a combination of services organized to meet the needs of a particular population (Sauber, 1983). A difficulty in creating a mental health service system stems from the varied, multiple needs of the client population. Since deinstitutionalization, many different service systems have been designated as responsible for meeting one or more of the individual needs of persons with long-term psychiatric disabilities (e.g., mental health, health, substance abuse, vocational rehabilitation, social security). The diverse needs of persons with severe psychiatric disabilities for housing, health care, economic, educational, vocational, and social supports dictates coordination between multiple service providers. The mental health service system has become the primary system responsible for preventing individuals who need services from being ignored or falling through the cracks. The challenge to the mental health field has been to develop a mental health service system that could consistently meet the diverse needs of all clients (Reinke & Greenley, 1986). In essence, not only must effective and relevant services be available, but they must also be well-coordinated so that they are easily accessible and efficient, without controlling the consumer to the point of simply replicating the

state mental hospital in the community. No doubt the most pressing, obvious national example of service system fragmentation is the system of services for people who have been labeled dually diagnosed, i. e., people with psychiatric disabilities and substance abuse problems (Drake, McLaughlin, Pepper, & Minkoff, 1991; Ridgely, Goldman, & Willenbring, 1990; Ridgely & Dixon, 1995).

Although many studies have noted that multiple, fragmented service systems can interfere with effective service delivery to persons with psychiatric disabilities, until the 1980s little systems-level research was undertaken (Anthony & Blanch, 1989). In 1977, Armstrong reported that 135 federal programs in 11 major departments and agencies had direct impact on people with mental illness. He reported that many of the failures of deinstitutionalization could be attributed to funding disincentives and lack of coordination among these programs (Armstrong, 1977). Other early evidence of the need for system development and integration included the interrelationship of health and mental health as demonstrated by the frequent conflict between services rendered by primary care physicians and mental health professionals (Burns, Burke, & Kessler, 1981). Currently, the integration of behavioral managed care and physical health care is a major concern of those planning managed care systems. Also making system development difficult is the fact that existing funding streams have conflicting regulations and eligibility criteria (Dickey & Goldman, 1986).

Moreover, the lack of coordination directly affects clients. Tessler (1987) found that when clients do not connect with resources after discharge from inpatient care, their overall community adjustment is poorer and there are more complaints about them. On the other hand, poor coordination is sometimes

blamed for failures actually due to insufficient resources or inappropriate services (Solomon, Gordon, & Davis, 1983). At some point, the sheer quantity of services (or lack thereof) does affect quality. Research has not yet clarified the relationship between the numbers, types, or coordination of services and client outcome.

Anthony and Blanch (1989) categorized various attempts at ensuring the integration of services into four types, according to whether they emphasized (a) legislated relationships and program models, (b) financing mechanisms, (c) strategies for improving interagency linkages, and/or (d) assignment of responsibility. Many initiatives have, of course, incorporated several of these elements.

Within the last several decades, data collection on systems level interventions has occurred sporadically. One example is the previously mentioned work of Harding (Desisto, et al., 1995a, 1995b) that involved comparing the long-term outcome of people with psychiatric disabilities served by two different systems in two separate states. This study concluded that differences in recovery outcome were probably due to system wide differences in psychiatric rehabilitation programming. Another example is the ongoing research investigating various Community Support System (CSS) services. In the 1990s the National Institute of Mental Health and later the Center for Mental Health Services (CMHS) initiated nationwide a number of research demonstrations of essential CSS service components, including vocational rehabilitation, case management, crisis response services, and other supportive services (Jacobs, 1998). An analysis of the results of 29 projects found that the majority of the studies reported positive findings on one or more of the following outcomes: symptomatology, consumer outcomes (e.g., competitive employment), satisfaction with services,

and service utilization. More recently, ongoing CMHS demonstrations should inform system planners and policy makers into the next decade.

Another CMHS sponsored research initiative examined the impact of service integration on housing outcomes for persons who were homeless and mentally ill using data from the Access to Community Care and Effective Services and Supports (ACCESS) program (Cocozza, Steadman, & Dennis, 1997; Rosenheck et al., 1998). Results showed a significant relationship between measures of service system integration and independent housing outcomes.

A final example of systems level research is the effort launched by the Robert Wood Johnson (RWJ) foundation in the late 1980s. The RWJ initiative was based on the fundamental assumption that a central authority would enhance continuity of care, and that such improvements would lead to improved client outcomes. Nine cities were selected on a competitive basis to develop community-wide systems of care (Shore & Cohen, 1990). Within the 5-year demonstration period each city was expected to create a local mental health authority that would assume central responsibility for developing and coordinating public sector services. For the most part the RWJ system initiative did not attempt to improve practitioner competencies and program standards; rather, RWJ focused almost exclusively on organization and financing. Little significant consumer impact was found (Lehman, Postrado, Roth, McNary, & Goldman, 1994; Shern, et al., 1994).

ORIGIN OF THE RECOVERY-ORIENTED SYSTEM STANDARDS

Unlike the development of standards for particular program models, there are no standards for recovery-oriented systems. Typically, standards have been most often considered in the development of model programs, such as Assertive Community Treatment (ACT), (Teague, Drake, & Ackerson, 1995), IPS (Becker & Drake, 1993; Drake, 1998), Clubhouse (Beard, Propst, & Malamud, 1982) and Choose-Get Keep (Anthony, Howell, & Danley, 1984; Anthony, Cohen, Farkas & Gagne, (in press)). A comparable set of standards has not been advanced for a recovery oriented mental health system. Furthermore, there is no model of a recovery oriented mental health system currently operating, although as pointed out previously, a number of systems are declaring the development of a recovery oriented system to be their intent. Direction and guidelines are needed to stimulate and reinforce the development of a recovery oriented system. The system that existed for most of the last century was based on the notion that people with severe mental illness do not recover, and that maintenance and care of people with severe mental illness should be the goal.

Lacking a currently functioning model system for guidance, it becomes necessary to suggest the system level standards that might be helpful for system designers. The recovery oriented system standards outlined in Table 3 are meant to serve as a starting point of reference and as a guide for system development. Furthermore, the identification of system standards on which each system is based allow for system level research to be more meaningful. In addition, technical assistance for system development can use the standards as a jumping off point.

The particular standards identified in Table 3 are derived from several sources. First, they are consistent with the systems level research that has so far occurred. Secondly, they are compatible with the aforementioned recovery principles. Lastly, the system level consultants of the Boston University Center for Psychiatric Rehabilitation and its affiliate BCPR reviewed each standard and made changes to the standards based on their consultative experience. Standards were not included unless there was consensus. Over the last 17 years consultants from these organizations have on average provided technical assistance and training in about 17 states and three countries per year.

RECOVERY SYSTEM STANDARD DIMENSIONS

The standards have been grouped according to the system level dimensions which best describes the focus of the standard. However, this categorization of standards is done for ease of presentation and not as part of a deliberate attempt to characterize how system standards must be organized. As the standards are used, modified and refined, new ways to organize and name the system dimensions will no doubt occur.

Design

The mission and outcomes of the system incorporate the language of recovery. Consumers and their families are integrally important in the design process. The identified mission and consumer outcomes include such dimensions as improvements in role functioning, empowerment, consumer satisfaction, and quality of life. The mission is achieved through a set of identified services (see Table 2) which, when combined together, contribute to the achievement of the recovery outcomes (Anthony, 1993). A specific *service* (e.g., crisis intervention

services, case management services) is defined by its unique process and outcomes. A *setting* is defined by its location (e.g., inpatient, community mental health center). A *program* is defined by certain administrative, staffing, and service standards (e.g., intensive case management program, clubhouse program). The system is designed around the CSS configuration of services and is *not* designed around a specific set of programs or settings; rather programs and settings must indicate which of the services they provide and on what consumer outcomes they will be held accountable. For example, a PACT program may indicate that they provide treatment, rehabilitation, crisis intervention, and case management services, and that they are accountable for implementing the process associated with each of those services.

Evaluation

Each program providing services in the system must identify the unique consumer outcomes they will achieve. For example, in rehabilitation services, no matter what the rehabilitation program is called (e.g., IPS, Clubhouse) and no matter what the setting (e.g., psychosocial rehabilitation center, mental health center), the service must achieve improvements in the consumers' role functioning (see Table 2). Treatment services must achieve symptom alleviation, and so on. Outcomes assessments must always include the perspectives of consumers and family members.

Leadership

The vision of recovery must be present in most all of the leadership's written and public statements. Recovery is such a paradigm shifting notion (Anthony, 1991), that its fundamental assumptions and principles must constantly be reinforced. Recovery is a vision incompatible with the mission of the mental health system of the past century. The leadership must demonstrate through

Table 3—Characteristics of a Recovery-Oriented System

SYSTEM	DIMENSION	RECOVERY SYSTEM STANDARD	EXAMPLE OF CURRENT NONRECOVERY STANDARD
Design	Mission includes recovery vision as driving the system	Mission includes description of service principles (e. g., continuity of care)	
	Mission implies recovery measures as overall outcome for system (e. g., empowerment, role functioning)	Mission implies no measures of recovery outcome (e. g., comprehensive range of services)	
	Core set of needed services are identified for system (e. g., treatment, rehabilitation)	Core set of programs or settings are identified for system (e. g., day treatment programs and inpatient settings)	
Evaluation	Primary consumer outcomes identified for each service are measurable and observable (e. g., number of crises, percentage of people employed)	Outcomes for each service are process measures or program quality measures only (e. g., number of people seen in service; time before first appointment)	
	Consumer and family measures of satisfaction included in system evaluation	Consumer and family perspectives are not actively sought for system evaluation	
Leadership	Leadership constantly reinforces recovery vision and recovery system standards	Leadership vision is focused on developing specific programs or settings	
Management	Policies insure that a core set of processes (i. e., protocols) are described for each identified service	Policies do not insure that service protocols guide service delivery	
	Policies expect programs within each service to have policies and procedures directly related to implementing the service process	Policies and procedures are about staffing, physical setting, and so forth, and not about service process	
	Policies insure that MIS system collects information on service process and outcomes	Policies focus MIS on collecting information on types of clients served and costs, but not on service processes and outcomes	
	Policies insure that supervisors provide feedback to supervisees on service process protocols as well as on progress toward consumer goals	Policies on supervision do not focus on supervisors providing feedback on protocols and consumer goals; primarily on symptomatology and medication	
	Policies encourage service programs to be recovery friendly (i. e., procedures are compatible with recovery values)	Policies encourage service programs to value compliance and professional authority	
Integration	Function of case management is expected to be performed for each consumer who wants or needs it	Case management function is not expected to be provided to all who want or need it	
	Standardized planning process across services that is guided by consumer outcomes	Planning process varies between services, and is not guided by consumer outcomes	
	Policies encourage the development and implementation of system integration strategies to achieve specific consumer outcomes	Policies on system integration strategies do not address development, implementation, and evaluation of such strategies	
	Referrals between services include consumer outcomes expected of service provider	Service referrals include consumer descriptions rather than consumer outcomes	

Table 3—Characteristics of a Recovery-Oriented System (continued)

SYSTEM DIMENSION	RECOVERY SYSTEM STANDARD	EXAMPLE OF CURRENT NONRECOVERY STANDARD
Comprehensiveness	Consumer goals include functioning in living, learning, working, and/or social environments	Consumer goals do not include functioning in living, learning, working, and social environments (typically only residential environment)
	Consumer goals include functioning in nonmental health environments, not controlled by the mental health settings (e. g., YMCA, religious organizations)	Consumer goals emphasize adjustment in mental health environments
	Consumer goals include outcomes from any of the identified services	Consumer goals include outcomes for only a few of identified services
Consumer Involvement	Policies insure that programs provide an array of settings and a variety of levels of supports within a setting	Policies allow programs to provide a limited array of settings and supports within settings
	Consumers are actively sought for employment at all levels of organization	Consumers are not actively sought for employment at all levels of employment
	User-controlled, self-help services are available in all geographic areas	User-controlled, self-help services are not available or available in only a few geographic areas
Cultural Relevance	Consumers and families integrally involved in system design and evaluation	Consumers and families are involved in a token way in system design and evaluation—if at all
	Policies insure that assessments, planning, and services interventions are provided in a culturally competent manner	Policies with respect to assessments, planning, and services intervention do not take cultural diversity into consideration
	Policies insure that the knowledge, skills, and attitudes of personnel enable them to provide effective care for the culturally diverse populations that might wish to use the system	Policies related to personnel do not attend to issues of cultural diversity
Advocacy	Policies insure that settings and programs and the access to them reflect the culture of their current and potential consumers	Policies only insure that settings and programs are compatible with the predominant culture
	Advocates for a holistic understanding of people served	Advocates primarily for particular programs, settings, or disciplines
	Advocates for consumers to have the opportunity to participate in community roles	Advocates for consumers to have the opportunity to participate in mental health programs
Training	Advocates for an understanding of recovery potential of people served	Advocacy for understanding of recovery potential of people served is lacking
	Policies insure that all levels of staff understand recovery vision and its implications within service categories	Policies make no mention of recovery vision nor its implications for services
	Policies encourage selection and training methods designed to improve knowledge, attitudes, and skills necessary to conduct particular service that staff is implementing	Policies on selection and training based on interests of staff or training coordinator

Table 3—Characteristics of a Recovery-Oriented System (continued)

SYSTEM DIMENSION	RECOVERY SYSTEM STANDARD	EXAMPLE OF CURRENT NONRECOVERY STANDARD
Training	Policies insure that all levels of staff understand recovery vision and its implications within service categories	Policies make no mention of recovery vision nor its implications for services
	Policies encourage selection and training methods designed to improve knowledge, attitudes, and skills necessary to conduct particular service that staff is implementing	Policies on selection and training based on interests of staff or training coordinator
Funding	Dollars across services are expended based on consumers' expressed needs	Dollars across services are expended based on information other than consumer needs
	Dollars across services are expended based on expected process and outcomes of services	Dollars across services are expended based on historical, traditional funding
Access	Access to service environments is by consumer preference rather than professional preference	Access to environments is based primarily on professional decisions
	Access to service environments is not contingent upon using a particular mental health service	Access to service environments is contingent on participation in certain mental health services
	Access to living, learning, working, and social environments outside mental health system is expected	Access to living, learning, working, and social environments outside mental health system is not encouraged

their words and actions that they and everyone else in the system need to “buy in” to this dramatically new direction.

Management

System management, through system level policies and procedures, must ensure that each individual service define itself by the unique process they use. Service protocols are developed and implemented so that the basic service processes are possible to monitor (Anthony, 1998). An MIS system exists for each service. For example, the basic protocol for case management might include process components such as setting a service goal, planning, linking and negotiating for service access. The protocol for rehabilitation might include setting the overall rehabilitation goal, functional assessment, resource assessment, planning, skill development and resource development. Supervisory sessions revolve around effective ways to implement the protocol. System management looks for “recovery oriented”

values in the programs they fund, and staff assignment to programs is based, to the greatest extent possible, on competencies and preferences, rather than credentials.

Integration

The system polices include the provision of case management for all who need and want it. Each service, within the array of services offered by the system, has a standardized planning process that shares some common process elements across services, that is, each service contains the major process elements that are standard across services. Common process elements might be: an *assessment* of the consumer's goal(s), a *plan* to reach the goal(s), and specific *interventions* to achieve the goal(s). For example, enrichment services might perform an assessment to determine which enrichment activities the consumer prefers, *plan* how to access that activity, and *intervene* by providing or arranging the preferred recreational, social, and so forth activity according to

the plan. Case management services might *assess* the person's service goal, *plan* for accessing those services, and *intervene* through linking and/or negotiating for those services. In addition, when referrals occur between different service programs, the referral includes a specific description of the consumer outcomes the receiving service is expected to achieve.

Comprehensiveness

All the possible residential, work, educational and social environments in which a consumer might potentially function are included as a consumer goal(s) and measurable consumer outcome(s). Functioning in nonmental health environments (e. g., schools, social clubs) are included as goals. It is the policy of the system that consumer supports that facilitate a consumer's functioning are provided in a wide variety of environments. A particular support exists in more than one environment. For example, intensive residential support may be

provided in group residences, but also in an individual's own apartment.

Consumer Involvement

Selection and recruitment materials for staff throughout the system target consumers and family members for employment, as well as voluntary service on boards. User-controlled services are available in all the designated catchment areas served by the system.

Cultural Relevance

The system promulgates policies designed to increase the possibility that the system reflects the culture of the consumers served. Specifically, policies on cultural competence address the training and experience of practitioners, the assessment, planning, and intervention process, and culturally relevant programs and procedures to access them.

Advocacy

System advocacy occurs for the recovery vision, for a holistic understanding of the persons served, and for consumers to have the opportunity to participate fully in community roles.

Training

System level policies on training are designed so that delivery of specific services is improved; training is grounded in the vision of recovery, and not just in the interest of certain staff.

Funding

Funding from the system is based on the consumers' recovery goals. Funding directly supports the processes and outcomes that the system is designed to achieve.

Access

Policies encourage access to services based on the consumers' goals rather than professional preference. Access is not contingent upon the consumer attending certain mental health services. For example, access to housing is not contingent on taking medication. Access

to nonmental health environments is expected.

CONCLUSIONS

As system planners use all or some of these standards they will undoubtedly modify, refine and/or add to these standards. This first attempt at providing recovery oriented system standards should prove useful in a number of ways. First of all, it can provide direction to system planners as they develop proposals for their system. It can provide a basis for consumer and family advocacy and monitoring at the system level. The standards can be used in system level research and evaluation of recovery oriented systems, and as a framework to make comparisons across systems. Lastly, as these standards outlined in Table 3 are put into use, it will further encourage the operationalization of these standards.

These recovery oriented system standards are a first step in moving a system with no recovery vision to a system that believes that consumers can develop meaningful and purposeful lives, despite having experienced the catastrophe of severe mental illness. A mental health system guided by a recovery vision must have policies and procedures in place to increase the possibility of recovery occurring—for the system itself as well as for those it serves.

REFERENCES

- American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- Anonymous (1989). How I've managed chronic mental illness. *Schizophrenia Bulletin*, 15, 635–640.
- Anthony, W. A. (1991). Researching the unresearchable! *Psychosocial Rehabilitation Journal*, 14(3), 1.
- 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. (1998). Psychiatric rehabilitation technology: Operationalizing the "black box" of the psychiatric rehabilitation process. *New Directions for Mental Health Services*, 79, 79–87.
- Anthony, W. A., & Blanch, A. K. (1989). Research on community support services: What have we learned? *Psychosocial Rehabilitation Journal*, 12(3), 55–81.
- Anthony, W. A., Cohen, M. R., Farkas, M., & Gagne, C. (in press). *Psychiatric rehabilitation* (2nd ed.). Boston: Boston University, Center for Psychiatric Rehabilitation.
- Anthony, W. A., Howell, J., & Danley, K. S. (1984). Vocational rehabilitation of the psychiatrically disabled. In M. Mirabi (Ed.), *The chronically mentally ill: Research and services* (pp. 215–237). Jamaica, NY: Spectrum Publications.
- Armstrong, B. (1977). A federal study of deinstitutionalization: How the government impedes its goal. *Hospital and Community Psychiatry*, 28, 417, 425.
- 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. (1993). *A working life: The individual placement and support (IPS) program*. Concord, NH: Dartmouth Psychiatric Research Center.
- Burns, B. J., Burke, J. D., & Kessler, L. G. (1981). Promoting health-mental health coordination: Federal efforts. In A. Brokowski, E. Marks, & S. H. Budman (Eds.), *Linking health and mental health*. Beverly Hills, CA: Sage Publications.
- Coccozza, J. J., Steadman, H. J., & Dennis, D. (1997). *Implementing system integration strategies: Lessons from the ACCESS program*. New York: Policy Research Associates.
- Cohen, M. R., Nemeck, P. B., Farkas, M. D., & Forbess, R. (1988). *Psychiatric rehabilitation training technology: Case management* (Trainer package). Boston: Boston University, Center for Psychiatric Rehabilitation.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11–19.

- DeSisto, M. J., Harding, C. M., McCormick, R. V., Ashikaga, T., & Brooks, G. W. (1995a). The Maine and Vermont three-decade studies of serious mental illness: I. Matched comparison of cross-sectional outcome. *British Journal of Psychiatry*, *167*, 331–338.
- DeSisto, M. J., Harding, C. M., McCormick, R. V., Ashikaga, T., & Brooks, G. W. (1995b). The Maine and Vermont three-decade studies of serious mental illness: II. Longitudinal course comparisons. *British Journal of Psychiatry*, *167*, 338–341.
- Dickey, B., & Goldman, H. H. (1986). Public health care for the chronically mentally ill: Financing operation costs: Issues and options for local leadership. *Administration in Mental Health*, *14*, 63–77.
- Drake, R. E. (1998). A brief history of the individual placement and support model. *Psychiatric Rehabilitation Journal*, *22*(1), 3–7.
- Drake, R., McLaughlin, P., Pepper, B., & Minkoff, K. (1991). Dual diagnosis of major mental illness and substance disorder. In K. Minkoff (Ed.), *Dual diagnosis of major mental illness and mental disorder*, 3–12. *New Directions for Mental Health Services*, No. 50. San Francisco: Jossey-Bass, Inc.
- Harding, C. M. (1994). An examination of the complexities in the measurement of recovery in severe psychiatric disorders. In R.J. Ancill, S. Holliday, & G.W. MacEwan (Eds.), *Schizophrenia: Exploring the spectrum of psychosis* (pp. 153–169). Chichester: J. Wiley & Sons.
- Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987a). The Vermont longitudinal study of persons with severe mental illness: I. Methodology, study sample, and overall status 32 years later. *American Journal of Psychiatry*, *144*, 718–726.
- Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, T. S., & Breier, A. (1987b). The Vermont longitudinal study of persons with severe mental illness: 11. Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry*, *144*, 727–735.
- Harding, C. M., Zubin, J., & Strauss, J. S. (1987). Chronicity in schizophrenia: Fact, partial fact, or artifact? *Hospital and Community Psychiatry*, *38*, 477–486.
- Houghton, J. F. (1982). Maintaining mental health in a turbulent world. *Schizophrenia Bulletin*, *8*, 548–552.
- Jacobs, J. (Ed.) (1998). *Community support research demonstration grants, 1989–1996: Major findings and lessons learned*. Rockville, MD: Center for Mental Health Services.
- Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal*, *23*(4), 333–341.
- Leete, E. (1989). How I perceive and manage my illness. *Schizophrenia Bulletin*, *15*, 197–200.
- Lehman, A., Postrado, L., Roth, D., McNary, S., & Goldman, H. (1994). Continuing of care and client outcomes in the Robert Wood Johnson Foundation Program on chronic mental illness. *Milbank Quarterly*, *72*(1), 105–122.
- McDermott, B. (1990). Transforming depression. *The Journal*, *1*(4), 13–14.
- National Institute of Mental Health (1987). *Toward a model plan for a comprehensive, community-based mental health system*. Rockville, MD: Division of Education and Service Systems Liaison.
- Reinke, B., & Greenley, J. R. (1986). Organizational analysis of three community support program models. *Hospital and Community Psychiatry*, *37*, 624–629.
- Ridgely, M., & Dixon, L. (1995). Policy and financing issues in the care of people with chronic mental illness and substance abuse disorders. In A.F. Lehman & L.B. Dixon (Eds.), *Double jeopardy: Chronic mental illness and substance abuse*. (pp. 277–295). New York: Harwood Academic Publishers.
- Ridgely, M., Goldman, H., & Willenbring, M. (1990). Barriers to the care of persons with dual diagnoses: Organizational and financial issues. *Schizophrenia Bulletin*, *16*, 123–132.
- Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Johnson, M., Goldman, H., Randolph, F., Blasinsky, M., Fontana, A., Calysn, R., & Teague, G. (1998). Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *American Journal of Public Health*, *88*(11), 1610–1615.
- Sauber, S. R. (1983). *The human services delivery system*. New York: Columbia University Press.
- Shern, D., Wilson, N., Coen, A. S., Patrick, D., Foster, M., Bartsch, D., & Demmler, J. (1994). Client outcomes II: Longitudinal client data from the Colorado treatment outcome study. *Milbank Quarterly*, *72*(1), 123–148.
- Shore, M., & Cohen, M. D. (1990). The Robert Wood Johnson Foundation program on chronic mental illness: An overview. *Hospital and Community Psychiatry*, *41*(11), 1212–1216.
- Solomon, P., Gordon, B., & Davis, J. M. (1983). An assessment of aftercare services within a community mental health system. *Psychosocial Rehabilitation Journal*, *7*(2), 33–39.
- 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.
- Spaniol, L., Gagne, C., & Koehler, M. (in press). The recovery framework in rehabilitation: Concepts and practices from the field of serious mental illness. In J. R. Finch & D. P. Moxley (Eds.), *Sourcebook of rehabilitation and mental health services*. New York: Plenum.
- Teague, G. B., Drake, R. E., & Ackerson, T. H. (1995). Evaluating use of continuous treatment teams for persons with mental illness and substance abuse. *Psychiatric Services*, *46*(7), 689–695.
- Tessler, R. C. (1987). Continuity of care and client outcome. *Psychosocial Rehabilitation Journal*, *1*(1), 39–53.
- Unzicker, R. (1989). On my own: A personal journey through madness and re emergence. *Psychosocial Rehabilitation Journal*, *13*(1), 71–77.