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**RECOVERY GUIDES:
AN EMERGING MODEL OF COMMUNITY-BASED CARE
FOR ADULTS WITH PSYCHIATRIC DISABILITIES**

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“We’re not cases, and you’re not managers” (Everett & Nelson, 1992, p. 49).

In the decade since the article with the above title appeared in print, the field of community mental health has become increasingly dissatisfied with traditional models of case management. This same period has seen significant advances in the development of new, safer and more effective, medications, psychiatric rehabilitation strategies, disorder-specific cognitive behavioral psychotherapies, and peer-run and other innovative services. In addition, the mental health consumer/survivor/ex-patient movement has made considerable inroads into mainstream mental health practice, moving the field from a despairing view of mental illness as a progressive, degenerative disease toward a more hopeful, recovery-oriented paradigm. Despite these significant advances it remains the case, however, that the predominant service offered to most adults with serious psychiatric disabilities is clinical case management (Sledge, Astrachan, Thompson, Rakfeldt & Leaf, 1995). Arguably there have been several advances in clinical case management practice during this period as well, from the intensive, team-based and *in vivo* approach of assertive community treatment to the introduction of strengths-based and rehabilitative forms of case management that attempt to shift the goals of care from stabilization and maintenance to enhanced functioning and community integration. As the title above suggests, however, these approaches continue to conceptualize the person with the disability as a “case” and the healthcare provider as a “manager.”

In this chapter, we argue that continued use of inherited models of case management limit the progress that otherwise could be made in actualizing this shift from a deficit- and institution-based framework to a recovery and community integration paradigm. We argue that this paradigm calls for new models of community-based practice that move beyond the management of cases and beyond merely semantic changes that introduce new terms for old practices (cf., e.g., Jacobson & Greenley, 2001). We suggest that one such model that appears to be emerging in the field is that of tour guide, community guide, or, as in the title for this chapter, “recovery guide.” Prior to introducing this model, we first 1) review existing models of case management that have underlain the last 40 years of community-based

practice. We then 2) outline the principles of care that ground a recovery-oriented alternative, 3) describe the key components of the recovery guide model, and, in closing, 4) consider some of the broader implications of this model for community-based practice.

<1>1. Inherited Models of Case Management

Case management arose out of the Community Support Program movement as an attempt to address several of the failures of deinstitutionalization (Anthony, Cohen, Farkas & Cohen, 1988; Parrish, 1989). In addition to being inadequately funded, the community-based systems of care that were developed to enable people with serious mental illnesses to leave state hospitals were so fragmented and uncoordinated that they have been described as “non-systems” of care (Hoge, Davidson, Griffith & Jacobs, 1998). As it was practically impossible for people seeking care to navigate these complex and unintegrated health and social service systems on their own, the role of case manager was created and initially tasked with identifying, accessing, and coordinating various services to meet the multiple needs of individuals with serious mental illnesses living in the community (Hoge, Davidson, Griffith, Sledge & Howenstine, 1994; Sledge, Astrachan, Thompson et al., 1995). The primary responsibility of case managers working under these conditions was to assess client needs, attempt to link clients to appropriate services (termed “brokering”), and monitor their service use and outcomes.

When it became apparent that lone case managers could not ensure access to or coordination among services over which they had no administrative or fiscal authority, team-based approaches to case management were developed in which mental health professionals both provided as well as “brokered” care (Hoge, Davidson, Griffith et al., 1994). The most well-articulated and rigorously evaluated team-based approach to intensive case management was developed in the 1970s by Stein and Test (1980), who initially named their approach the Program for Assertive Community Treatment (PACT). PACT or ACT, as it has since come to be more commonly known, and various other derivative versions of intensive case management are characterized by the provision of comprehensive care in natural community settings enabled by lower client to staff ratios, caseloads that are shared amongst teams of professionals, 24-hour emergency coverage, and time unlimited services (Bond, 1991; Mueser, Bond, Drake & Resnick, 1998).

As we describe below, this shift to the provision of direct care by an outreach-based team of professionals gave the first impetus to the recovery guide model of practice.

Concurrent with these developments, concerns that traditional community mental health services emphasized the impairments and areas of difficulty of people with psychiatric disabilities over their strengths and areas of competence gave rise to both strengths-based and rehabilitative approaches to case management (Mueser, Bond, Drake & Resnick, 1998). These approaches incorporate many of the principles of psychiatric rehabilitation (Anthony, 1993), emphasizing the importance of skill building as an avenue to promoting community tenure. These approaches also allow for more input and direction by the person with the disability as opposed to being driven by mental health professionals as experts with an accumulated body of knowledge. Finally, this approach stresses that the community, where most of the contact between case manager and client takes place, offers resources for, as well as presents obstacles to, the person's continued growth and development.

While these various approaches provide clarity in terms of the case manager's responsibilities in relation to the client, they provide little direction as to how the case manager is to fulfill all of these responsibilities. In other words, they instruct the case manager in *what* to do, but not necessarily in *how* to do it. For guidance in this regard, individual case managers are often left to their own devices, falling back either on what limited training they have received or on their own personal, largely intuitive, style of relating to others. As a result, we have found it useful in our experiences of training and supervising case managers to identify and make explicit the often implicit models that people have for how they are to do their jobs. While simplistic and reductive, these models have proven to be effective teaching tools in clarifying the various roles community providers can play in the lives of people with psychiatric disabilities. We present the most common of these models in Table 1, and, for each model, offer a metaphor for the role of the mental health professional and describe the interventions most associated with that role.

Insert Table 1 about here

The limitations of these various models will become apparent when viewed through the lens of the recovery movement and its community integration paradigm. In order to elaborate on this perspective, we offer a list of the “Top Ten Principles of Community-Based Care” that can inform a new model of community-based practice. With this model, we present an alternative role for mental health professionals working with adults with severe psychiatric disabilities and offer a detailed metaphorical exploration of the role of the “Recovery Guide” in facilitating their recovery and community integration.

<1>2. Top Ten Principles of Recovery-Oriented Community-Based Care

In contrast to the continued debate and lack of clarity over what the concept of “recovery” means in relation to severe psychiatric disability, a considerable amount of consensus has emerged on the core principles of recovery-oriented care (e.g., Anthony, 2000; Davidson, Stayner, Nickou, Styron, Rowe & Chinman, 2001; Jacobson & Greenley, 2001; Ridgway, 2001). Based on our review of this literature (e.g., Davidson, O’Connell, Tondora, Staeheli & Evans, 2003; O’Connell, Tondora, Evans, Croog & Davidson, 2003), we have distilled the following top ten principles by which any new, alternative model of clinical practice should be assessed. Although overlapping, each principle addresses a unique and important dimension of recovery-oriented care.

<2>Principle #1: Care is recovery-oriented

Although this principle may seem a bit self-serving (or tautologous), it nonetheless should be stated first and foremost that mental health care needs to be grounded in an appreciation of the possibility and nature of recovery in severe mental illness. As described in the recent *Mental Health: a Report of the Surgeon General*: “All services for those with a mental disorder should be consumer-oriented and focused on promoting recovery” (Department of Health and Human Services, 1999, p. 455). This dictum stands in stark contrast to the last 150 years of mental health care; an era based on a maintenance and stabilization framework, at best, or on a model of progressive deterioration, at worst. The notion that many people can recover from a serious mental illness is relatively new, and the implications of this recognition have yet to be translated fully into practice (Harding, Zubin & Strauss, 1987).

As one implication of this shift, people need to be offered hope and/or faith that recovery is “possible for me.” Having a sense of hope and believing in the possibility of a renewed sense of self and purpose is essential to recovery. This sense of hope may be derived from religious faith or from others who believe in the potential of a person, even when he or she cannot believe in him or herself (Davidson, Stayner, Nickou et al., 2001; Deegan, 1996a; Fisher, 1994; Jacobson & Curtis, 2000; Jacobson & Greenley, 2001; Mead & Copeland, 2000; Smith, 2000). The therapeutic role of hope as an essential element in promoting recovery has been described as follows:

“Hope sustains, even during periods of relapse. It creates its own possibilities. Hope is a frame of mind that colors every perception. By expanding the realm of the possible, hope lays the groundwork for healing to begin” (Jacobson & Greenley, 2001, p. 483).

In addition to hope, recovery from mental illness, broadly defined, involves a process of overcoming some of the consequences of illness; gaining an enhanced sense of identity, empowerment, and meaning and purpose in life; and developing valued social roles, citizenship, and community connections despite a person’s symptom profile or continued disability (Cooke, 1997; Davidson, Stayner, Nickou et al., 2001; Deegan, 1996a). In recent years, there has been a growing emphasis on developing mental health care that supports, rather than hinders, people’s opportunities to participate in such processes of healing. As a departure from earlier, less hopeful, practices that promoted low expectations for people diagnosed with severe mental illness, implementing a recovery vision requires a change in the manner in which care is conceptualized and delivered based on belief in the potential of people with psychiatric disabilities to improve over time. Recovery-oriented care would thus include practices that: 1) help people gain autonomy, power, and connections with others; 2) aid in skill development as well as symptom management and treatment; 3) focus on abilities and strengths, rather than deficits; and 4) are guided by the person in recovery. As mental health professionals, we should be asking our clients questions about their hopes, dreams, interests, talents, and skills, and perhaps the most important question—“How can I best be of help?”—in addition to assessing their problems and difficulties (Carling, 1995). As suggested by Carling (1995), when working with clients, mental health professionals can

evaluate the extent to which they are providing recovery-oriented services by asking themselves: “Does this person have more or less power as a result of this interaction?” (p.60). We recommend expanding this question to: “Does this person *gain* power, purpose (valued roles), competence (skills), and/or connections (to people) as a result of this interaction?” and, equally important is the converse: “Does this interaction *interfere* with the acquisition of power, purpose, competence, or connections to others?”

<2>Principle #2: Care is strengths-based

A further implication of the above shift is recognition that traditional mental health services have been organized around a narrow medical model that perceives mental illness as a disease that must be “treated” and “cured” (Corrigan & Penn, 1998). By focusing on the assessment and treatment of the deficits, aberrations, and symptoms—the things that are “wrong” with people—providers have had a tendency to overlook all that remains “right” with people, i.e., their remaining and co-existing areas of health, assets, strengths, and competencies (Davidson & Strauss, 1995). Because there doesn’t yet exist a “cure” for mental illness, emphasizing the negative has led to a tremendous sense of hopelessness and despair among both clients and the mental health professionals serving them. A recovery orientation encourages us instead to view the glass as half full. Based on Rappaport’s principles of empowerment (1981), this perspective allows us to see that, no matter how disabled: “All people have existing strengths and capabilities as well as the capacity to become more competent” (Grills, Bass, Brown & Akers, 1996, p. 129). As a result of this recognition, we come to appreciate that “the failure of a person to display competence is not due to deficits within the person but rather to the failure of the social systems to provide or create opportunities for competencies to be displayed or acquired” (Grills et al., 1996, p. 130). By focusing on strengths rather than deficits, people can begin to identify and develop greater competencies, assets, and resources upon which to expand their opportunities (Rapp, 1993; Rapp & Wintersteen, 1989), promoting the development of an upward positive spiral of competence, leading to increased health, and increased competence (Davidson, 2003).

The process of rediscovering one’s remaining areas of health and one’s talents, gifts, and possibilities may begin when the individual can acknowledge and accept the limitations imposed by his or

her illness (Hatfield, 1994; Munetz & Frese, 2001; Smith, 2000; Sullivan, 1994; Young & Ensing, 1999). This acknowledgement and acceptance does not mean accepting one's identity as a "mentally ill person," however. Accepting one's illness has to do with redefining how a person thinks about and understands life's challenges (Ridgway, 2001). Patricia Deegan (1988), for example, describes a "paradox of recovery, i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do." Gaining a sense of perspective on one's strengths and weaknesses is critical in the process of recovery as it allows the person to identify, pursue, and achieve life goals despite the lingering presence of disability (Deegan, 1988, 1993; Hatfield, 1994; Munetz & Frese, 2001; Ridgway, 2001; Sayce & Perkins, 2000; Smith, 2000; Sullivan, 1994; Young & Ensing, 1999). Within this view, limitations become the "ground from which spring our own unique possibilities" (Sayce & Perkins, 2000, p.74). As a person recovers from illness, the illness then becomes less of a defining characteristic of self and more simply one part of a multidimensional self that also contains strengths, skills, and competencies. Care then, to be recovery-oriented, must elicit, flesh out, and cultivate these positive elements at least as much as, if not more than, assess and attempt to ameliorate, decrease, or remediate difficulties.

<2>Principle #3: Care is community-focused

Following on the heels of the early days of deinstitutionalization, the National Institute of Mental Health recognized that the multiple needs of people with serious mental illnesses living in the community were not being addressed by existing care, and thus designed and disseminated a model of community treatment that focused on housing, income maintenance, medical care, and rehabilitation in addition to traditional mental health services (Turner & TenHoor, 1978). Turner and Schifren described the resulting Community Support System initiative of the 1970's as promoting the development of a "network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (1979, p. 2). Somewhere along the way, however, care that was designed to be community-focused became confused with care that was simply community-based, with the *focus* of care being replaced by the *locus* of care (Stein, 1989).

In addition to being provided outside of hospital settings, community-focused care is that which: 1) is primarily provided in a person's natural community; 2) facilitates the development of relationships with people in one's community; 3) helps people develop citizenship and roles that are of value to one's community; and 4) works with members of the general community to combat stigma and increase access to resources. Rather than simply trying to fix the individual, and as suggested in Rappaport's reframing of failure described above, community-focused care views the incongruence between the person and his or her environment as the target for intervention. This is done by helping the individual assimilate into his or her environment (through symptom management, skill acquisition, etc.) and by helping the community and the environment to better accommodate people with disabilities (through education, stigma reduction, the creation of niches, etc.). The goal is to develop "multiple pathways" into and between members of communities (Dailey, Chinman, Davidson, Garner, Vavrousek-Jakuba, Essock, Marcus & Tebes, 2000).

<2>Principle #4: Care is person-centered

American society places tremendous value on the freedom to exercise choice in everyday life. Constrained only by access to resources, it is assumed that all adults have the right and responsibility to make their own decisions about where they live, what they do, and how they want to be treated, as long as these decisions do not infringe on another person's rights. During the century of institutional care, these rights and responsibilities were denied to inmates of the asylum, as they were viewed as incapable of taking care of themselves. Unfortunately, this view did not disappear altogether with the downsizing of state mental hospitals, but instead has been carried, to various degrees, into community treatment settings, recreating an institution without walls in the community (Davidson, 1997; Estroff, 1995). Continuing to be viewed as largely incapacitated by their psychiatric disorder, people with severe mental illnesses have yet to be accorded the same rights to autonomy and self-determination, or the same responsibilities for self-care, as the general public. As a result, traditional mental health models still typically view clients as passive recipients of the care and ameliorative efforts of others (i.e., cases to be managed) rather than as active participants in, and agents of, their own recovery (Davidson, 1997; Deegan, 1996a).

A person-centered model of care is one that is guided by the person with the disability, reflects his or her own wants, needs, and preferences, involves primary relationships as sources of support, focuses on capacities and strengths, and accepts risks, failures, uncertainties, and setbacks as natural and expected parts of learning and self-determination (Gerteis, Edgman-Levitan, Daley & Delbanco, 1993; O'Brien & Lovett, 1992). In such a model, providers learn to “do nothing without the client’s approval, involving clients in decisions regarding every step of the process.” In addition, according to this model, “opportunities to move each client closer to being the director of the case management scenario [are to] be found, created, and exploited” (Rapp, 1998, p. 374). For this model to be effective, of course, people with disabilities need to continue to feel like members of society despite their disability status, as opposed to being subsumed by their illness or diagnostic label. If the illness is allowed to rob the individual of his or her personhood and all of the socially valued roles that accompany it, the patient role is often one of the few that remain (Estroff, 1989). This process neither promotes insight nor breaks through the individual’s presumed denial, but rather promotes the illness to a master status. But, as Deegan observes, when the person’s “identity [becomes] synonymous with a disease, then there is no one left inside to take on the enormous work of recovery” (1996b, p. 12). Even though it often leads to the rejection of conventional mental health services precisely because of the damage they can do to a person’s self-esteem and identity, people need to resist such attempts to raise the illness to master status by redefining one’s self as a person of whom mental illness is simply one part. As we described in our earlier research: “The process of rediscovering and reconstructing an enduring sense of self as an active and responsible agent provides an important and perhaps, crucial, source of improvement” (Davidson & Strauss, 1992).

<2>Principle #5: Care allows for reciprocity in relationships

The recovery process entails regaining both a sense of agency in one’s life and a sense of belonging and self-worth within a community of one’s peers (Davidson, Stayner, Nickou et al., 2001). Personal agency involves not only feeling effective and able to help oneself but also being able to positively impact the lives of others. We have long known that it can be therapeutic to give of oneself to others (Biegel & Tracy, 1994; Riessman, 1990). However, many clients have become so accustomed to

receiving care and having decisions made for them that they may feel they have little of value to share. Furthermore, people with psychiatric disabilities may be accustomed to having their offers of reciprocity rejected because the traditional therapeutic boundaries and professional roles held by many mental health providers forbid this sort of two-way street. The largely asymmetrical and unidirectional relationships that exist between professionals and clients create a situation in which “staff hold the power to allocate or give based on their judgment” (Curtis & Hodge, 1994, p. 25) and may contribute to a passivity that carries over into other, more naturally occurring, relationships (Davidson, Stayner & Haglund, 1998).

Providers can help clients gain a sense of agency and self-worth by treating them as “fully competent equals,” by accepting appropriate gestures of reciprocity, and by encouraging participation in self-help (Mead & Copeland, 2000). In addition, it may be for this reason that the development of valued social roles and involvement in meaningful activities have been identified as cornerstones of the recovery process, as they provide people with a sense of self-worth and purpose in life (Anthony, 1993; Davidson, Stayner, Nickou et al., 2001; Ridgway, 2001; Young & Ensing, 1999). It is extremely difficult to have a sense of belonging to one’s community without a sense of what one has to contribute to that community and what roles one can play in it. As summarized concisely by Jacobson and Greenley: “To connect is to find roles to play in the world” (2001, p. 483)—preferably roles that benefit others as well as oneself. This principle was articulated eloquently by a participant in an earlier study who said the following during the course of a qualitative interview:

“I could choose to be a nobody, a nothing, and just [say] ‘the hell with it, the hell with everything, I’m not going to deal with anything.’ And there are times when I feel like that. And yet, I’m part of the world, I’m a human being. And human beings usually kind of do things together to help each other out, that type of thing. And I want to be part of that. . . . If you’re not part of the world, it’s pretty miserable, pretty lonely. So I think degree of involvement is important . . . involvement in some kind of activity. Hopefully an activity which benefits somebody. I have something to offer . . . that’s all I’m talking about. And I

think [this project] made it a little bit easier for me to think in those terms, to not be afraid to give things to people, and not be afraid to take things from people in return” (quoted in Davidson, Haglund, Stayner, Rakfeldt, Chinman & Tebes, 2001, p. 288).

<2>Principle #6: Care is culturally-responsive

As documented in the recent supplement to *Mental Illness: A Report of the Surgeon General* entitled *Mental Health: Culture, Race, and Ethnicity* (Department of Health and Human Services, 2001a), people from ethnic and racial minority groups are both over-represented and yet under-served among recipients of public sector mental healthcare. While the prevalence of psychiatric disorders may be comparable across cultural and racial groups, access to care, service use, and health outcomes are not. Significant disparities exist in each of these domains, evident in the fact that people of color are able to find few, if any, effective services that are tailored and responsive to their unique social and cultural background. These service utilization patterns also may be linked to data that suggest that some forms of traditional treatment may be less effective or even detrimental when used with ethnic minority populations. For instance, Spanish-speaking families have been found to experience an increase in symptoms when treated with highly structured family therapy and to experience a reduction in symptoms with the use of less structured case management services (Telles, Karno, Mintrz, Paz, Arias, Tucker & Lopez, 1995). As this example suggests, one of the reasons for the disaffiliation of people of color from mental healthcare is the lack of sensitivity of traditional services to their cultural and racial identity. In addition to a mistrust of the mental health system (Becerra, Karno & Escobar, 1982; Grier & Cobbs, 1968; Gutierrez, Ortega & Suarez, 1990; Neighbors, Elliott & Gant, 1990), there also are characteristics of traditional services that run counter to the values of these communities. For both African and Hispanic Americans, for example, these characteristics include a reliance on institutions as opposed to personal relationships and extended peer and family networks and a focus on the individual as opposed to the group (Butler, 1992; Grier & Cobbs, 1968; Gutierrez, Ortega & Suarez, 1990; Neighbors, Elliott & Gant, 1990).

The lack of congruence between cultural values and traditional mental health services, in combination with disparities in service access, utilization, satisfaction, and outcomes, prompted the Surgeon General to call for expanded research to clarify when and how traditional treatments ought to be adapted, or new ones developed, to meet the needs and preferences of people of color. Leaders in the field of mental health have begun to respond to this challenge by developing culturally responsive services to address some of the needs of multicultural populations (Department of Health and Human Services, 2001b). When developed programmatically, these services can be oriented to the local community and attempt to optimize use of local resources.

It is difficult, however, even for culturally-responsive programs to be tailored to the unique cultural identities of specific individuals. We know from research on ethnic identity development, for example, that not all individuals from a particular ethnic background, even if it is from the same specific subgroup (e.g., Afro-Caribbean or Chilean), will identify to the same degree and in the same ways with their cultural heritage and its traditional values (Casas & Pytluk, 1995; Pope-Davis, Liu, Ledesma-Jones & Nevitt, 2000; Vandiver, 2001). Based on a number of factors, such as length of time in the U.S. and family context, tremendous variability can be found within even the smallest enclaves of ethnic minority communities, leading to the truism that no two Native Americans or Hispanic Americans will be exactly alike with respect to their ethnic identity. As a result, recovery-oriented care not only needs to be attentive to cultural differences across race, ethnicity, and other distinctions of difference (e.g., sexual orientation), but must incorporate this sensitivity at the level of the individual client. Only an individual-level process can ensure that providers avoid stereotyping people based on broad or inaccurate generalizations (e.g., what all lesbians want or need), and enable them instead to tailor services to the specific needs, values, and preferences of each client, taking into account each individual's ethnic, racial, and cultural identification and affiliations. Although this is a relatively under-developed area that we feel warrants significant attention in the future, we also view the recovery guide model as providing a particularly

efficient yet comprehensive framework for addressing issues of culture, race, ethnicity, and other distinctions of difference, as we describe below.

<2>Principle #7: Care is grounded in the person's life-context

Care that is grounded in a person's "life-context" acknowledges, builds on, and appreciates each person's unique history, experiences, situations, developmental trajectory, and aspirations (Davidson & Strauss, 1995). In addition to culture, race, and ethnicity, there are less visible but equally important influences on each individual's development, including both the traditional concerns of mental health professionals (e.g., family composition and background, history of hospitalizations) as well as less common factors such as personal interests, hobbies, and role models that help to define who we are as individuals. Because many people with psychiatric disabilities have found their illness to subsume who they were as people prior to becoming ill, providers often fall into viewing people as if they were born with a mental illness and did not have a life beforehand (Davidson & Strauss, 1995). Also, many people with psychiatric disabilities become accustomed to living on the margins of society and become resigned to a life of invisibility. To address both of these consequences, providers must understand the impact that marginalization has had on the person and on his or her expectations of life, and encourage the person to reconnect to who he or she used to be as one possible bridge to becoming who they want to be despite the limitations imposed by his or her disability. Appreciation of an individual's life-context, too, represents an under-developed but important dimension of recovery-oriented care, and will be described further below through the lens of the recovery guide.

<2>Principle #8: Care is relationally-mediated

Recovery is not a solitary process or a journey that one traverses alone; it is a fundamentally social process (Jacobson & Greenley, 2001). Supportive relationships, whether they are with family, friends, professionals, community members, or peers, allow individuals to become interdependent in a community that can both share in their disappointments and pain and revel in their joy and successes (Baxter & Diehl, 1998; Fisher, 1994; Jacobson & Greenley, 2001; Mead & Copeland, 2000; Ridgway,

2001; Smith, 2000; Sullivan, 1994; Young & Ensing, 1999). In addition, people in recovery often describe the importance of having someone believe in them when they could no longer believe in themselves, and often attribute their recovery, more than anything else, to someone “really believing in me” or “seeing something inside me that I couldn’t see” (Davidson, Stayner, Nickou et al., 2001; Ragins, 1994). Regardless of the number of tools or interventions a service provider uses, it thus cannot be emphasized enough that at the heart of any effective intervention is the relationship between the provider and client (Anthony, 1993). Like other caring people in the person’s life, mental health providers must believe in the individual even when he or she cannot believe in him or herself and serve as a gentle reminder of his or her potential. To promote recovery, providers must be able to envision a future for the client beyond the role of “mental patient” based on the client’s own desires and values and must share this vision with the client through the communication of positive expectations, optimism, and hope.

Consistent with this principle, the establishment of trusting, supportive relationships through persistence and consistency is considered by some to be the most fundamental requirement of recovery-oriented care. In the presence of such relationships, the illness no longer remains the primary focus of the person’s life, and the person is then able to move on to other interests and activities (Anthony, 1993). With this kind of encouraging support, people will be more likely to expand their horizons and take risks that they haven’t taken before. To maximize the benefits of this process, providers must be more than just “case coordinators.” They must also be willing to fill gaps in needed service areas and “to assist clients in developing their own individual visions and journeys of recovery through the process of defining meaning and purpose in their lives” (Lunt, 2000, p. 402). Unfortunately, but consistent with the assumptions of the models described above, a major factor missing in the conceptualization of case management is often this emphasis on or permission for the development of a genuine relationship between the case manager and the client—a relationship which then mediates the process of growth and recovery. It is for this reason, among several others, that we suggest the need for alternative models of practice.

<2>Principle #9: Care optimizes natural supports

Traditional mental health systems have been described as tending to “surround people with serious mental health problems with a sea of professionally delivered services . . . which stigmatize them and set them apart from the community” (Nelson, Ochocka, Griffin & Lord, 1998, p. 881). A recovery-oriented model of care helps minimize the role that professionals play in clients’ lives over time and maximize the role of natural supports such as friends, family, neighbors, and other community members. Rather than substituting for such networks, mental health providers can help people “mobilize” their own support networks through the development of new ties and the maintenance and strengthening of existing ties (Biegel & Tracy, 1994). One strategy for expanding relationship networks is to tap into and “place a premium on the use of existing available community resources like families, volunteer opportunities, neighbors, junior colleges, sports leagues, YMCAs, faith communities, and arts centers” (Rapp, 1998, p. 371). In order for mental health providers to facilitate these connections, they must have an intimate knowledge of the communities in which their clients live, the community’s available resources, and the people who are important to them, whether it is a parent, friend, landlord, or grocer. Service providers also must be knowledgeable about informal support systems that are in communities such as support groups, singles clubs, and other special interest groups, and be willing to learn more about other possibilities that exist to help people connect.

This kind of knowledge is difficult if not impossible to generate from the armchair in the office. Similarly, the process of connecting people can be, and often needs to be, done through more than a referral or brokering process. Helping people optimize natural supports requires developing connections yourself, being familiar with resources and friendly spots in the community, and routinely being involved in the community. Where pathways to community life seem largely absent for the individual, it is the job of the provider to develop active, intentional relationships with a range of community members and organizations so that the individual with the disability will have access to a range of normalized activities and socially valued roles through which he or she can leave behind the identity of “mental patient” and internalize the more healthy identities offered by his or her community of membership (Gilmartin, 1997;

Rappaport, 1995). Providers can then go with a client to a support group or social club or introduce a person to someone they know who is already a member (Carling, 1995). Such is the value of having providers who are well-integrated into their own communities—the task becomes easier as a provider’s own network expands.

<2>Principle #10: It (really) is your job

This principle may seem irreverent, but it is borne out of many years of experience and frustration in trying to conceptualize the role of the mental health provider as recovery-, rather than deficit-, oriented and as community-, rather than office-, based. Even after reading the first 9 principles above, many mental health professionals—despite their assurances that they have in fact adopted a recovery orientation—will continue to view all of these principles as somehow applying to someone else. It is good for clients to have hope for their futures, to explore community resources and activities, and to assume valued social roles through which they can contribute to the community—so this reasoning goes—but all of that is someone else’s concern, not mine. As a professional—the reasoning continues—my job is to conduct a thorough assessment, offer an accurate diagnosis, and provide effective treatments for my clients’ disorders. It is not to ensure that they are having fun or being involved in meaningful activities, any more or any less than it is to ensure that they are living in safe and affordable housing, meeting their basic needs for food and clothing, or finding and maintaining gainful employment.

As suggested in the last principle, however, one of the more difficult, and perhaps less obvious, implications of adopting such a community focus is that mental health providers need to shift the locus of their efforts to offering practical assistance in the community contexts in which their clients live, work, and play. In order to effectively address “individuals’ basic human needs for decent housing, food, work, and ‘connection’ with the community,” providers must be willing to go where the action is, i.e., they must get out of their offices and out into the community (Curtis & Hodge, 1994, p. 15). They must be prepared to go out to meet people on their own turf and on their own terms, and to “offer assistance which they might consider immediately relevant to their lives” (Rosen, Diamond, Miller & Stein, 1993, p. 134). As described by Rosen, their job “is to draw all the fragments of services and resources which we find in the

community into a system and safety net around the service user, and even to recreate asylum, in the best sense, in the community; that is, a haven of safety and a harbor from which to set out again” (1994, p. 48). This safety net includes the need for supportive family and social relationships, meeting basic survival needs like food, clothing, and safe housing, and securing employment and other socially valued roles as well as accessing appropriate and needed psychiatric and physical healthcare.

Unfortunately, many mental health professionals, operating within the more traditional treatment paradigms reviewed above (in Table 1), prefer to work as office-based psychotherapists and to distance themselves from individuals with serious mental illness and from the problems they confront in their day-to-day lives (Rosen, 1994). When the therapist has the luxury of working with a dedicated case manager who is assigned to address the day-to-day issues, this also may function as a tool for distancing the therapist from the lived experience of the client and thus may remove him or her from the real world in which the clients’ problems arise, resulting in the clinician having “a clear picture of neither the problems nor the solutions” (Deitchman, 1980, p. 788). One of many examples of this process is provided by vocational rehabilitation. Through the kind of distancing entailed in making referrals to vocational rehabilitation specialists, mental health providers have demonstrated an unfortunate tendency of divorcing the meaning of work for people with severe psychiatric disorders from the various meanings that work has for the rest of us. In earlier work (Strauss & Davidson, 1997), we noted that this tendency has had a dehumanizing impact not only on clients but also on the providers who serve them:

“Work has been viewed primarily as adjunctive or as a support to treatment, with the expectation that recovery or cure will have to take place before work can return to playing a central role in the person's life. This view neglects the fact that the disabled person continues to live his/her life despite . . . the disorder, and that major dimensions of life such as work and social relationships may retain the meaning they had for the person prior to the onset of his/her illness. . . As soon as we turn our back on the body of first-person knowledge, the guide derived from our own lives, we start talking about ‘schizophrenics’ or ‘manic-depressives’ or ‘borderlines’ . . . Work loses its fundamental meaning and importance in human existence and comes to be seen as an adjunct or

support to a person's 'real' treatment. [In contrast,] work should be viewed as the bridge across which a person can travel in leaving severe mental disorder and becoming an increasingly competent, intact, human being" (pp. 107-108).

In order to avoid this distancing and dehumanizing tendency, we recommended that providers draw upon their own experiences when considering the critical nature of the worker role—or of any other socially valued role for that matter—for all individuals, continuing to view the client squarely within the context of his or her daily life (Strauss & Davidson, 1997).

In addition to contributing to the dehumanizing of their clients, providers' insistence on office-based practice misses much of the significance of the shift to the recovery orientation for which we are arguing. It has not worked over the previous 25 years for many clients for their providers to postpone attending to their acquisition of meaningful and gratifying personal lives until after their illnesses have been treated (Scott & Dixon, 1995). Severe psychiatric disorders are often long-term, disabling conditions for which cures do not yet exist. People with these disorders cannot sit back and simply wait for their medications, or skills training groups, or other treatments to work before they start to attempt to get their lives back. Of course, people with psychiatric disabilities have known this all along, and many have gone about reclaiming their lives outside of, and at times despite, their mental healthcare. For care to make positive contributions to this process, all of the strategies, goals, and interventions that providers have at their disposal must be reframed as tools to be used in the person's own recovery.

In this vein, it is not simply the psychiatrist's job, for example, to diagnose and prescribe appropriate medications for a client's condition with the assumption that the client will take the medication and improve. From the perspective of a recovery orientation, it also becomes the psychiatrist's job to understand how the medication will affect other important dimensions of the person's life (e.g., a job or relationship) and to talk with the client about how medications can be used effectively as a tool in his or her own recovery. One client who is taking a risk to start a new job may need to increase his medication to offset his increased anxiety while another client starting a new job may need to decrease her medication to overcome its sedating effect in the morning so that she can get out of bed on time. Similarly, a

client taking risks in developing a new relationship may be concerned about a medication's effect on his or her sexual functioning. As it cannot be anyone other than the psychiatrist whose job it is to explore and understand these issues to prescribe medications effectively (Noordsy, Torrey, Mead, Brunette, Potenza & Copeland, 2000), it also cannot be anyone other than the guide's job to explore and understand the many other facets of the client's life in the community. Within a recovery orientation, there is no other job.

<1>3. The Emerging Model of Recovery Guide

Since the introduction of Stein and Test's Program for Assertive Community Treatment in the 1970's, intensive, team-based models of community-based practice have emerged as the service of choice for people seriously disabled by psychiatric disorders, particularly for those who have been "difficult-to-engage" in, or have been unresponsive to, conventional care (e.g., those who are homeless or who have co-occurring substance use disorders) (Bond, 1991). One of the major advances entailed in the ACT approach—and the one that makes ACT a particularly good point of departure for the development of recovery-oriented care—was the provision of skills training and other direct mental health services "in vivo," meaning in the natural community settings where they are actually needed as opposed to in a clinician or case manager's office. Rather than being a finished product, we suggest that this shift from office to community-based practice initiated with ACT represents a work very much in progress, with several steps still needing to be taken in fulfilling the more substantive promises of this new paradigm.

Adherents and practitioners of the ACT approach began to articulate some of these implications by contrasting the traditional role of case managers, which they likened to "travel agents," to their new role as outreach-based providers, which at first was conceptualized as that of "traveling companions." As described by Deitchman:

"The client in the community needs a traveling companion, not a travel agent. The travel agent's only function is to make the client's reservation. The client has to get ready, get to the airport, and traverse foreign terrain by himself. The traveling companion, on the other hand, celebrates the fact that his friend was able to get seats on the plane, talks about his fear of flying, and then goes on the trip with him, sharing the joys and sorrows that occur during the venture" (1980, p. 789).

As contained in this metaphor of the traveling companion, ACT staff cannot be content with sitting behind their desks and making appointments for their clients (i.e., the brokering model), as their clients may then frequently fail to show up for such appointments. Similarly, staff cannot be content with making suggestions regarding steps their clients may need to take in their lives (e.g., seeking employment), as clients may then either disregard or be unable to follow such suggestions on their own. Rather than waiting for their clients to show up at their office, it is incumbent upon the staff to meet the clients where they are in the community and to facilitate their participation in such activities, to the point of actually accompanying them if necessary.

Although representing a significant first step toward a new model for community-based practice, there are at least a couple of problems with the traveling companion metaphor. First, as we found above with the model of consumer or peer advocates, the traveling companion image suggests that the staff and client share a relationship of two friends traveling together. This image fails to capture the fact that staff are assigned to assess and address the client's needs and are paid for their service, suggesting a false reciprocity between the two parties. As argued by Rosen (1994) and Rosen, Diamond, Miller, and Stein (1993)—experienced ACT proponents all—ACT staff should no more be confused with friends or peers due to their community location than should traditional office-based case managers. For this reason, they suggest the image of a tour guide as opposed to that of a traveling companion, the tour guide metaphor preserving the staff member's status as a care provider and the resulting, largely asymmetrical nature of the relationship. This notion of tour guide closely resembles the notion of "community guide" proposed by John McKnight in his work with adults with developmental disabilities. A community guide, according to McKnight, is an individual who "assume[s] a special responsibility for guiding excluded people out of service and into the realm of the community" (1992, p. 59). In addition to providing a service for which he or she is reimbursed (unlike friendship), it is important for community guides to learn, according to McKnight, "that in order for the fullness of community hospitality to be expressed and the excluded person to be wholly incorporated as a citizen they must leave the scene" (1992, p. 59). In other words, rather than becoming an enduring figure in the person's life, community guides play a

transitional role in facilitating the person's engagement in social relationships with peers in the community. Guides are neither peers nor friends, but tools for the person to use in reconnecting to the things that matter to him or her.

The notion of tour or community guide in this way represents a step beyond that of traveling companion. Even this revision falls short of capturing the full flavor of community-based practice, however, in at least one important respect. Simply stated, most people with severe psychiatric disabilities do not readily or willingly seek out the assistance of a guide. The journey of mental illness is not a trip that anyone wants to take and thus is one for which people are unlikely to contact mental health providers for assistance, at least in the early phases of the illness. These phases are more commonly characterized by confusion, cognitive interference, withdrawal, and shock. Due to the stigma that continues to accrue to mental illness in popular culture, the lack of education or information provided to the lay public regarding psychiatric disorders, and the denial and disbelief that accompanies the onset of many serious illnesses, people often struggle with serious mental illness for many years before coming to understand that what they are struggling with *is* a psychiatric disorder. It then may be another prolonged period before they can muster the courage and trust to accept their need for treatment and support. As a result, community-based practitioners cannot assume that clients will come to them of their own volition out of a genuine desire to receive guidance from a mental health expert—or for that matter, a community guide—just as they cannot assume that clients will be appreciative of their efforts to offer assistance when clients do not yet accept or recognize that they need it. Should a person willingly seek out the assistance of a tour guide to navigate the complex health and social systems required to access needed services, or seek out a community guide to help him or her reclaim his or her life in the broader community, then the provider's job is made considerably easier. Early in the course of illness, however, this is more the exception than the rule.

The rule suggests instead that the first job of the provider, even prior to becoming a community guide, is to *engage* a reluctant and disbelieving, but nonetheless suffering, person in care. For this reason, we prefer the term “recovery guide” for the primary role of the mental health provider in working with people with serious mental illness, defining this role as an expansion upon the tour or community guide

through explicit recognition and incorporation of the need for engagement as the first step in developing the trusting relationship that then can be put to use in guiding the person along the path of recovery. We thus begin our exposition of the roles and responsibilities of the recovery guide here, with the first lesson to be learned in working with people with serious mental illness, which we define as the following:

<2>Lesson #1: Most people will not know that they have a psychiatric disorder at first, and therefore will not seek help on their own. The initial focus of care thus should be on the person's own understanding of his or her predicament (i.e., not necessarily the events or difficulties which brought him or her to your attention), and on the ways in which the provider can be helpful in addressing this predicament, regardless of how the person understands it at the time.

The recovery guide needs to take the prospective client's own perception of his or her difficulties as the point of departure for any efforts to be effective in developing a trusting relationship that then can serve as the cornerstone for other helping efforts. In the common parlance of community-based practitioners, this is captured by the phrase "meeting the client where he or she is at." This lesson was learned initially in conducting outreach to persons who were homeless, when outreach staff began to realize that people were more responsive to offers of coffee and a sandwich, concrete assistance with securing housing, or meeting other basic needs than to offers of psychiatric treatment or medication. Extrapolating from this rather extreme situation to more common ones, providers need to attend to what the prospective client is concerned about most, regardless of its relationship to his or her mental illness. In this respect, providers also cannot assume that everyone with a mental illness experiences the illness in the same way, or has had similar experiences of seeking or receiving help in the past. In fact, people have many different ways of accounting for the disruptions, interruptions, and difficulties brought about by the illness, ranging from the perception that he or she is being conspired against by others, to his or her unique relationship to God, to the effects of previous accidents or substance use, to punishments for earlier sins. Rather than viewing these perceptions or beliefs as further evidence of the client's illness, we suggest that it is more useful to view them as representing the client's best efforts to make sense of her or his own experiences—without the benefit of our knowledge and expertise (Davidson, 2003). In addition, the client's attitudes

toward you and the kind of assistance you have to offer will be shaped by his or her previous experiences with psychiatric treatment and the mental health system as a whole, particularly if he or she has had experiences of involuntary commitment or forced medication. Despite your most benevolent intentions, suspiciousness toward mental health services and a legitimately earned skepticism regarding providers' motives may make the engagement process complicated and protracted.

In prior research involving interviews with clients of an assertive community treatment team (Chinman, Allende, Bailey, Maust & Davidson, 1999), we learned that clients may resist the engagement efforts and guidance of ACT staff if they perceive that they are being asked to do things by strangers that have not yet taken the time to get to know them as a person. This research suggested that while there is value in offering problem-specific psychoeducation and other clinical interventions, there is equal, if not more, value in getting to know the individual first independent of his or her illness, e.g., the person may be an accomplished pianist, a lover of pepperoni pizza, or a nervous mom worried about losing custody of her children. Engaging the person around one of his or her interests or concerns may prove to be key to establishing yourself in the client's eyes as an individual who is genuinely interested in, and concerned about, his or her well-being.

In addition to meeting the client where he or she is and expressing a genuine interest in him or her as a person, efforts with prospective clients who have come to mistrust the mental health system and others in general need to be repetitive and persistent over time. Efforts to be persistent in engaging the client should not, however, supercede the overarching goal of establishing and maintaining a trusting relationship with the client. The recovery guide must be careful to allow the individual the right to decline his or her overtures, advice, and other interventions, and to enter into the relationship at a pace that is comfortable for him or her. In the study mentioned above, one ACT staff member coined this the "velvet bulldozer" approach (Chinman, Allende, Bailey et al., 1999) to capture the gentle but persistent way in which he had had to pursue one of his particularly reluctant clients.

The phenomenon represented by the velvet bulldozer has been described from both the client's as well as the provider's perspective. From the client's perspective, this is described as people "sticking by

me” or “believing in me even when I no longer believed in myself” (Davidson, 2003). When asked by the research interviewer what she thought had been most helpful about the ACT team to which she had been assigned following years of rejecting treatment, for example, the client who was being pursued by the velvet bulldozer explained: “They kept showing up . . . they didn’t drop me or let me get off the medications . . . they didn’t give up, they just stuck with me.” It was only after several months of repeated efforts to engage this client that she first began to have some trust in the staff’s concern and intentions toward her. And it wasn’t until she began to feel understood by the staff after several more months that she began to listen to what they were saying and consider their recommendations, loosening her hold on the isolation and daily substance use to which she had become accustomed. Eventually, she was able to reveal that she had been a practicing architect before the onset of her affective disorder, showing the staff some of her sketches as she began to take on a more active role in her own recovery.

The kind of patience and persistence required by this type of work is obviously not for everyone. As described by Estroff, this type of approach “appeals to people who do not know the meaning of the word ‘no.’ They don’t like the status quo; they will try anything to help their clients and they are not loyal to institutions or to centers, only to the people they are working with” (Estroff, as cited in Rosen, 1994, p. 61). In more positive terms, the process of gentle but persistent pursuit was captured eloquently by Saint-Exupery in his children’s tale *The Little Prince* (1943). In this tale, a young prince travels the galaxy, learning important lessons from the various people, animals, and plants he meets on his way. When he reaches the earth, he learns what it means “to tame” a fox in the following passage:

“Good morning,” said the fox.

“Good morning,” the little prince responded politely. “Who are you?” he asked, and then added,

“You are very pretty to look at.”

“I am a fox,” the fox said.

“Come and play with me,” proposed the little prince. “I am so unhappy.”

“I cannot play with you,” the fox said. “I am not tamed.”

“Ah! Please excuse me,” said the little prince. But after some thought, he added: “What does that mean—‘to tame’?” . . .

“It is an act too often neglected,” said the fox. “It means to establish ties.”

“‘To establish ties’?”

“Just that,” said the fox. “To me, you are still nothing more than a little boy who is just like a hundred thousand other little boys. And I have no need of you. And you, on your part, have no need of me. To you, I am nothing more than a fox like a hundred thousand other foxes. But if you tame me, then we shall need each other. To me, you will be unique in all the world. To you, I shall be unique in all the world. . . My life is very monotonous,” he said. “I hunt chickens; men hunt me. All the chickens are just alike, and all the men are just alike. And, in consequence, I am a little bored. But if you tame me, it will be as if the sun came to shine on my life. I shall know the sound of a step that will be different from all the others. Other steps send me hurrying back underneath the ground. Yours will call me, like music, out of my burrow. And then look: you see the grain-fields down yonder? I do not eat bread. Wheat is of no use to me. The wheat fields have nothing to say to me. And that is sad. But you have hair that is the color of gold. Think how wonderful that will be when you have tamed me! The grain, which is also golden, will bring me back the thought of you. And I shall love to listen to the wind in the wheat . . .”

“What must I do, to tame you?” asked the little prince.

“You must be very patient,” replied the fox. “First you will sit down at a little distance from me—like that—in the grass. I shall look at you out of the corner of my eye, and you will say nothing. Words are the source of misunderstandings. But you will sit a little closer to me, every day . . .”

The next day the little prince came back.

“It would have been better to come back at the same hour,” said the fox. “If, for example, you come at four o’clock in the afternoon, then at three o’clock I shall begin to be happy. I shall feel happier and happier as the hour advances. At four o’clock, I shall already be worrying and

jumping about. I shall show you how happy I am! But if you come at just any time, I shall never know at what hour my heart is to be ready to greet you . . . One must observe the proper rites . . .” In the case of community-based practice, the “proper rites” include such things as calling clients ahead of time so as not to show up unannounced (unless, of course, you expect the client to make sure he or she is not there when you arrive), setting up regular times for contact, not giving up or becoming defensive in response to repeated rejection, and being available to assist the client with things he or she is interested in doing or needs when he or she is ready to do so.

<2>Lesson #2: Regardless of whether or not he or she sought your help, recognize that the client had already embarked on his or her own journey before meeting you.

Once an initial sense of trust and engagement with the recovery guide is in place, staff may move to those components of their role that are more consistent with the guide metaphor. It is important to remember, however, that the client was already on his or her own journey before the onset of the illness, and before he or she came into contact with the recovery guide. As much as having a serious psychiatric disorder may have interrupted or interfered with the client’s aspirations and plans for his or her life, the journey that follows still has to be connected in meaningful ways to what came before. In other words, clients’ lives did not begin with the onset of their disorders, just as their lives are not encompassed totally by psychiatric treatment and rehabilitation. While seemingly obvious perhaps, these points were driven home to us by some of the questions we fielded when we first started to use the tour guide metaphor in our teaching. Following an exposition of the various roles and resources of the tour guide, for example, one experienced clinician objected by saying: “That all sounds fine and good, but what if the client won’t get on the damn bus?!” It is not the recovery guide’s job to get the client to agree to “get on the bus.” Not only might clients prefer to take a taxi, ride a bicycle, or walk, but more importantly, clients are already on journeys of their own when we meet them. It is we who need to join their journey, get on *their* bus, so to speak, rather than try to persuade them to get on ours.

Once we recognize that the client was already on a journey prior to the onset of his or her illness, and therefore prior to meeting us, the focus then shifts to the ways in which this journey was impacted by

his or her illness. How has his or her psychiatric disorder changed the person's aspirations, hopes, and dreams? If the person appears to be sticking resolutely to the hopes and dreams he or she had prior to onset of the disorder, and despite or in denial of the disorder and its disabling effects, then what steps need to be taken for him or her to get back on track or to take the next step or two along this track? Rather than the reduction of symptoms or the remediation of deficits—goals that we assume the client will share with *us*—it is the client's own goals for his or her life beyond or despite his or her disability that need to drive the treatment planning and rehabilitation efforts.

Once these goals have been identified and articulated, recovery guides have a number of tools at their disposal to facilitate the client's progress toward achieving them. The recovery guide's professional/clinical training and knowledge provide some of these tools, helping the client work towards recovery by providing education about serious mental illness, the recovery process, coping strategies, and the person's options, and by translating mental health procedures, services, and language into understandable and usable information. The guide's expertise should not be taken as a substitute for knowing the needs, interests, and strengths of the client, however. The guide's expertise also cannot be imparted to the client in a straightforward manner, as if giving a person cognitive strategies or telling a person what to do ever leads to significant personal change. Instead, the content and course of the journey must be directed by the client's own experiences, preferences, and concerns, rather than those of the guide. The client, in consultation with the guide, can choose where to go, when, and in what manner, and whether to stroll leisurely through scenic routes or to charge ahead on a more direct but rocky path. This is partly because the client will have a better sense of his or her own stamina and energy level, his or her ability to tolerate frustration and set backs, and the pace of change at which he or she feels most comfortable. It also is due to the fact that it is the client's life that ultimately has to change to support recovery and thus it is the client who must do much of the hard work of recovery him or herself. In addition to providing tools for the trek, the guide can share with the client ways of making the journey safe, sustainable, and satisfying.

<2>Lesson #3: Rather than dwelling on the client's distant past or worrying about the client's long-term future, recovery guides focus on the next several steps of the journey and on the sites that lie ahead.

Psychodynamic approaches to psychotherapy and clinical case management have long been criticized for focusing on clients' distant pasts rather than on their present circumstances and needs. One example of this practice was given by a participant in the ACT study described above, who reported that she stopped seeing an office-based psychotherapist for her affective disorder and alcohol dependence when this person only wanted to focus on her childhood memories and their presumptive effects when she felt that she had pressing concerns in her day-to-day life. "She kept telling me that I hadn't gotten over my father's death," she complained, "Like whoever does?" When this clinician sent her a letter informing her that she was going to be discharged from treatment for missing too many appointments, the woman described wanting to frame the letter as her "graduation diploma," feeling that this was the only way she would be able to leave the mental health system behind.

In the opposite direction, clinical psychiatry has made profound and far-reaching mistakes in telling clients and their families that illnesses like schizophrenia or manic-depressive psychosis were death sentences from which they would never recover (e.g., North, 1987). Although perhaps no longer suggesting that families grieve for the loss of their adult child recently diagnosed with serious mental illness as if he or she had died, it is still routine for providers to inform clients that they will have to take their psychiatric medications "for the rest of your life, just like you would have to take insulin for diabetes." Not only do we lack credible evidence on which to base such statements (i.e., many people stop taking their medications later in the course of their recovery without undue effects), but long-term pronouncements of any sort are typically not very helpful to anyone, including people receiving mental health services. As we now know that there is a vast heterogeneity in outcome for serious mental illnesses and that diagnosis can no longer predict prognosis (e.g., Carpenter & Kirkpatrick, 1988; Davidson & McGlashan, 1997; Harding, Zubin & Strauss, 1987; McGlashan, 1988), providers should refrain from pretending that they have a crystal ball through which they can predict their client's long-term future.

It is in this respect, among others, that the recovery guide model can be particularly helpful in directing the provider's attention toward the "sites" most likely to be of interest to their clients. Tour guides neither dwell on their clients' histories prior to their current excursion, nor do they worry about

what their clients will be doing when they return home following the trip. In addition, while they may provide some overall information about the entire trip at its inception, such as listing the historical sites they will be visiting, good guides focus primarily on the next one or two sites coming up immediately so as both to hold their clients' interest while not inundating them with too much information. If the bus is on the way to the Eiffel Tower, for example, the guide does not drone on about Notre Dame Cathedral or bestow praises on the Arch of Triumph. Certainly the guide does not try to prepare his or clients for the next leg of their trip by recounting the history of the Roman Coliseum when the tourists are still in Paris.

In this respect, the recovery guide's primary focus is on helping to prepare the client for the *next one or two steps* of the recovery process by anticipating what lies ahead in the near future, by focusing on the characteristics and challenges of the present situation, and by identifying and helping the client avoid or move around potential obstacles in the road. This idea of looking forward in the client's recovery is dramatically different from the focus of several of the previous models, as suggested above, and is crucial to adopting a recovery orientation. Although the recovery guide de-emphasizes early personal history (because it may not be relevant) and long-term outcomes (because we cannot predict them), either of these perspectives may be invoked should they prove useful in the current situation. As we will describe in more detail below, clients who become stuck in patterns of relating or failing at certain tasks may need assistance in understanding and liberating themselves from the legacy of their past. Demoralized and hopeless clients who view mental illness as a death sentence may need to be given information about the heterogeneity of long-term outcome and their chances for improvement. In general, however, recovery guides have their hands full focusing on supporting the client's efforts in the present. This forward-looking orientation requires the recovery guide to provide a context for the new experiences and learning of the client, but with a clear awareness that the journey is guided by the preferences, goals, and interests of the client rather than by some imaginary ideal of normalcy held by the provider to which the client is supposed to aspire (Davidson & Strauss, 1995).

<2>Lesson #4: Your credibility and effectiveness as a recovery guide are enhanced to the degree that you are familiar with, and can anticipate, interesting sites, common destinations, and important landmarks along the way.

This lesson derives directly from lesson #3 above. As a result of the recovery guide's focus on the next one or two steps in the journey, it is helpful for guides to develop a familiarity with the territory of recovery and to be able to anticipate interesting sites, common destinations, and important landmarks that clients are likely to encounter along their way. This is not to contradict the highly personal nature of each individual's journey. Despite the unique characteristics of each individual's struggle, there remain areas of commonality and overlap, issues and concerns that may be shared amongst a number of people who face some of the same challenges in coping with and compensating for their disorder. Examples of such shared concerns include relevant health services (e.g., medication options, medical treatment for other illnesses) and social services (e.g., accessing entitlements or support for parenting issues), learning skills for independent living (including finding safe and affordable housing and managing the responsibilities of being a tenant), and dealing with developmental issues of separation and individuation that have been delayed or prolonged by the onset of the illness. Self-help and peer support groups might be included as a way for clients to share common experiences and gain the support of others who are working on the same issues. Other landmarks may include finding opportunities to socialize outside of mental health centers or clubhouses. Involvement in meaningful activities, like work or education, or doing something creative and beyond the scope of traditional treatment, can help clients move beyond the relationship with the recovery guide into the broader community—the destination of choice for most people. These common destinations are outlined in Figure 1, along with the range of resources and tools the recovery guide has at his or her disposal in facilitating the client's exploration of these and other sites of interest.

Insert Figure 1 about here

The resources and tools that the recovery guide has at his or her disposal include professional training and experience; these are not to be discounted, no matter how conventional they may be. There are many other resources and tools that the guide has at his or her disposal, however, that have not been emphasized as much in the models described earlier. These include a hopefulness toward clients and their potential for improvement that has been lacking in earlier eras, the client's own aspirations, interests, assets, and goals which drive the recovery and service planning activities, the observations, input, and resources of family members and other important people in the client's life and community, and the recovery guide's own personal experiences, particularly his or her experiences as a member of the same community to which his or her clients belong. This last point is worth noting, as it is one of the resources that is related directly to the notion of the guide as opposed to that of detective, teacher, coach, etc. In psychoanalytic training for example, much was made of the trainee's need to be in psychoanalysis him or herself in order to become familiar with his or her own blind spots and to become immersed in the analytic process. McKnight makes a parallel point about the need for the community guide to have an active investment in, and extensive familiarity with, his or her local community in order to make use of these resources in his or her work with clients. "Most effective guides," writes McKnight, "are well connected in the interrelationships of community life. They have invested much of life's energy and vitality in associational activity. Based upon these connections, they are able to make a variety of contacts quickly because 'they know people who know other people'" (1992, pp. 59-60).

In addition to the client's assets, interests, and goals, the resources and input of his or her natural supports, and the guide's own professional knowledge and personal experience, it is useful for the guide to be familiar with, and be able to anticipate, the concerns and questions that commonly arise for people in different phases of recovery. Early in the course of illness and treatment, for example, people often wonder about the following issues:

- What is happening to me?
- How can I get rid of whatever this is that is happening to me? How can I make it stop?
- What can I tell my parents and other people who care about me?

- How can I catch up to my peers?
- How can I have a normal life?
- How can I keep this from happening again?

Guides can anticipate such questions as part of the preparation for the upcoming trek; knowing that these issues may be on a client's mind, and having accumulated valuable experiences with other clients who have struggled with these same issues, will enhance significantly the credibility and trustworthiness of the guide in the client's eyes. Similarly, it is common later in the course of the recovery process for issues such as the following to emerge as the person tries to make sense of his or her past and to create a new future based on what is possible now given his or her disability.

- What happened to me?
- Why did it happen? Why did it happen to *me*?
- What is possible for me now?
- How can I get there from here?

Clearly these are difficult, and at times impossible, questions to answer. These are the kinds of questions, however, which lie at the heart of the journey of recovery—whether or not the guide chooses to attend to them. To be able to share these concerns with the guide and accept the guide's involvement in his or her struggles, the client must be able to trust that the guide has his or her best interests in mind and that the guide will not willingly or knowingly lead him or her to a dangerous place. The guide can earn this trust by not giving false information about the language or customs of the country they are visiting together, by respecting the client and his or her central role in the recovery process, and by not ridiculing, disparaging, criticizing, or judging the client. This trust also includes faith in the guide's professionalism and competence which the client develops over time as he or she becomes confident that the recovery guide will act in an ethical and knowledgeable way, has the power and knowledge to open doors and make things work, and is aware of and open to a range of options from which the client can make

meaningful choices. Without both forms of trust, the client is unlikely to invite the guide to join him or her on the next leg of the journey.

Once the journey is underway, the recovery guide must be able to assess and follow the interests and preferences of the client. Just as it would be inappropriate for a tour guide to take you to France if you want to go to India, so too would it be counterproductive and inappropriate for the recovery guide to try to get a client a job at Wendy's when he or she expresses an interest to work at Macy's. Once client preference has been made clear, the recovery guide must be willing to engage and join with the client in pursuit of the client's own goals. This may mean coordinating medical care among a number of providers, investigating employment opportunities, helping the client to enroll in classes or become involved in community activities, helping to navigate the Medicaid system, or working with family members to create a compassionate and supportive recovery environment. Through these and other joint explorations, this process is oriented toward assisting the client in creating a life outside of or beyond his or her disability.

Throughout this entire process, the issue of client choice and self-determination is key. Offering clients meaningful choices, and respecting and honoring those choices, can pose real dilemmas for recovery guides, however. For example, what if the person refuses to choose to go along with his or her physician's recommended treatment regimen? What if he or she continues to refuse all services, or insists on choosing to disregard the guide's efforts, showing what the guide considers "poor judgment"? The first step that the guide will need to consider in such circumstances is to reconsider what is being offered to, or recommended for, the client from the client's own perspective. What is being offered to the client? What is entailed in following the recommended regimen? Does it move the client in the direction of his or her own goals and interests? Does the client perceive it to be useful or helpful in achieving what he or she wants to achieve? Is it consistent with the client's own beliefs, goals, hopes, and strengths? In short, is it a tour or leg of the journey worth taking (from the client's perspective)?

If the guide remains convinced of the value of the options not taken, then he or she may need to consider the possibility that the client is already embarked on a different leg of the journey that may not be obvious to us. In other words, he or she may be too busy pursuing other options to take the detour we

are recommending. Again, the guide needs to consider whether what he or she is offering will impede or facilitate the journey that the client has already begun. In the end, it is ultimately the client's life and the client's journey, so it must be the client's decision of which paths to follow and which to ignore, pass by, or try to keep in mind for a later, more fortuitous, time. In circumstances that do not pose serious and imminent risks to the client (e.g., active suicidal ideation with intent) or to others (e.g., assaultive behavior), all of us, as Patricia Deegan has reminded us, need the opportunity and freedom to learn from our own mistakes. Guides must accordingly afford their clients, in Deegan's words, "the dignity of risk" and "the right to failure" (1996a, p. 97).

<2>Lesson #5: Guides prepare for the journey by acquiring tools that will be effective in addressing or bypassing symptoms and other sequelae of the illness that act as barriers to the client's recovery.

A final, major area of focus for the guide involves assessing the potential obstacles that might lie in the client's path and working collaboratively with the client to find ways to address, overcome, or bypass these barriers as they arise. Many conventional clinical and psychotherapeutic skills can be incorporated into this component of the recovery guide's backpack, as long as the guide has the requisite training and supervisory resources available to deliver these interventions competently. We have found that moving what traditionally have been office-based practices into community settings requires more clinical skill, sophistication, and supervision than office-based practice rather than less. The challenges of deploying more flexible boundaries and enabling the development of a less unidirectional relationship while continuing to act in the client's best interest alone raise many thorny ethical and practical issues which have yet to be fully and adequately addressed. Without these skills and the ability to use them effectively in reducing, overcoming, or bypassing barriers to the client's recovery, however, the recovery guide will have a significantly diminished backpack, and thus a significantly depleted capacity for being truly helpful in facilitating the client's journey.

Rather than simply transferring these skills from the office to the recovery guide's backpack, preparing clinical skills for use "on the street" requires a shift in perspective. This shift entails focusing less on symptom reduction *per se* and more on assessing, anticipating, and addressing barriers that get in

the way of what the client wants to, or is trying to, do. Obviously, this requires having a sense of what the client is trying to accomplish as well as how specific symptoms, cognitive deficits, stigma, or other barriers get in the way of the pursuit of these goals. While it is true that conventional clinical practice has emphasized the promotion of health and competence as well as symptom and deficit reduction, it also is true that most models of serious mental illness assume that a person's symptoms and other areas of dysfunction need to be reduced or contained *before* he or she can resume normative activities such as attending school, obtaining and maintaining competitive employment, living independently, etc. We now know, however, that many people can live independently, attend school, work, and have gratifying personal relationships even while continuing to experience symptoms and other sequelae of their illness (Davidson, Stayner, Nickou et al., 2001). Our previous research also has suggested that to the degree that these issues are addressed, clients will be better prepared and more motivated to take an active role in their own treatment and rehabilitation (Davidson, Stayner, Lambert et al., 1997). On both humanitarian and clinical grounds, then, recovery guides understand that people need not wait until their illness has been effectively treated and reduced in order to pursue their personal goals and aspirations and to derive meaning from, and take pleasure in, life.

Consistent with this lesson is the definition of recovery emerging in the consumer/survivor and psychiatric rehabilitation literatures, which suggests that the reduction or amelioration of symptoms and deficits is not as crucial to being "in recovery" as the attitude the person takes toward his or her condition and the person's ability to lead a meaningful life despite continuing disability (Davidson, O'Connell, Tondora et al., 2003). The recovery guide accepts this framework, and then goes about the work of reframing a variety of established interventions as tools to be used in promoting the person's reclamation of a dignified and gratifying life in the community. Within a recovery perspective, for example, medications are taken not simply to treat an illness, as antibiotics are taken to treat an infection (Davidson & Strauss, 1995), but are taken in order for the person to be able to work, to attend and concentrate in the classroom, or to keep his or her own apartment. Similarly, cognitive-behavioral interventions for delusions (e.g., Kingdon & Turkington, 1994; Fowler, Garety & Kuipers, 1998) are offered to clients not only

to decrease the suffering they experience due to their paranoid and persecutory ideas, but also so that they may develop and maintain satisfying relationships with their peers—including peers who do not have a mental illness—rather than continuing to be shunned and rejected by others based on their alienating behavior. An increase in symptoms can often be taken as an indication of a significant event or challenge occurring in the person's life, and may need to be attended to as a factor influencing the pace of the journey or the need for the person to stop at certain landmarks for rest and replenishment. Symptoms alone, however, should not be the cause of a cancellation of the journey altogether, or lead to indefinite delays in resuming the trek. On the contrary, people have been incredibly creative in finding their own ways to manage the symptoms and other sequelae of their illnesses, and guides need to learn from and be familiar with such coping strategies so that they may offer them to their clients along the way.

In addition to addressing the direct effects of the illness as obstacles in the person's path, an important component of recovery involves recovering from the collateral damage left in the wake of mental illness. Often this can mean recovering from the effects of life in the mental health system and having been socialized into the role of mental patient. This may also include dealing with the indirect effects of mental illness, like poverty, stigma, and fear. In practical terms, having a life costs money, and poverty is a major barrier to effective integration into the community. Addressing the issues of fear and stigma requires a constant awareness of their existence and of the many ways in which they marginalize and limit the opportunities of people who have a mental illness. The role of the recovery guide involves thinking and exploring with the client ways to open doors and enhance access to community involvements while remaining attentive to the ways in which stigma and fear arise and need to be addressed in the process of community (re)integration. To the degree that this at times requires broader community education, advocacy becomes an accepted part of the recovery guide's scope of responsibility.

Identifying and helping the client to overcome the various barriers to recovery that he or she encounters thus becomes an integral component of the work of the recovery guide. In order to do this work effectively, the guide needs to be familiar with the territory and anticipate the obstacles that people are likely to encounter, both from inside as well as from outside of the illness. Just as a mountain guide

would need to know how trails are laid out and where snow is most likely to fall in an avalanche, our recovery guide needs to be familiar with a variety of sources of information that speak to the common challenges and areas of increased vulnerability experienced by people with serious mental illnesses. In addition to the professional/clinical knowledge base they accrue in their training, this requires becoming familiar with, and seeking ways to apply, available literature on adolescent and adult development, family systems, and first person accounts of illness and recovery. Common issues of loss and grief, separation and individuation, and the need for valued social roles add to this body of knowledge. Finally, recovery guides, as mentioned above, need to be intimately aware of the important community resources that will benefit or interest their clients, including informal support systems in the community that exist outside of the formal mental health system. The standard of care to which recovery guides aspire includes knowing the territory of recovery, the various paths up and down the mountain and those specific to each client, and ways to translate this knowledge effectively into practical strategies that restore hope and functioning.

Discussion

In this chapter, we have presented the recovery guide as a useful framework through which mental health professionals can understand their role as a facilitator of recovery and community integration for people with serious mental illness. We have focused primarily on the ways in which the role of the recovery guide differs from traditional provider roles, and on how this role impacts the nature of the helping relationship. It also is important, however, to look beyond the immediate provider-client relationship and consider how systemic factors can either support or impede the journey of the client and his or her recovery guide.

Training and clinical supervision are areas in which mental health systems can make significant impact upon the professional development of service providers. The Recovery Guide model incorporates case management in the context of a clinical relationship with relaxed boundaries that must shift to accommodate each individual and his or her unique recovery journey. The guide might be called upon to help a client find furniture for a new apartment, offer testimony before the legislature, purchase a dress for Sunday services, or take a bus to visit an elderly parent. Each new situation can present a range of

ambiguous and complex boundary dilemmas. In fact, such dilemmas are so inherent to community-based clinical practice that Curtis and Hodge (1993) have suggested that providers who are not facing boundary issues in their daily work are probably not doing their jobs.

At the same time, the mental health field lacks clear guidelines for what is professional and/or appropriate behavior for community-based practitioners (Carey, 1998), and “relaxing the boundaries” goes against the very grain of what most professionals are taught in training programs and clinical supervision. The adoption of the Recovery Guide model thus necessitates new standards not only for mental health providers but also for the institutions and supervisors that prepare them for clinical practice. Training programs must counter the pessimistic messages which are often sent to students regarding the chronic course of mental illness by presenting narratives of, and forums with, people in recovery as well as clinical research studies which have documented that partial to full recovery is possible for at least one quarter, and up to two thirds, of people with schizophrenia and other severe psychiatric disorders. Similarly, the notion of “recovery,” and the provider’s role in promoting it, must be expanded beyond clinical stability and maintenance to incorporate the pursuit of a meaningful life and a positive sense of belonging in the community.

Clinical supervisors and managers in mental health systems can reinforce this perspective and support recovery guides by helping them to transfer their skills and knowledge from the classroom to the community. Often this involves drawing upon their own experiences as community-based practitioners or sharing the stories of people in recovery who speak and write about the types of relationships and services that are helpful and not helpful. For example, mental health professionals are frequently taught to maintain professional distance from their clients as a means of retaining objectivity in the helping relationship. Yet, while there are certainly negative consequences of over-involvement for both the staff and clients, people report that “greater damage may be done by rigid enforcement of the traditional connotation of professional distance” than by boundary violations (Curtis & Hodge, 1994, p. 24). Supervisors must therefore allow recovery guides to reflect upon the “getting to know” aspect of their work, as it is this

aspect—the trusting relationship between guide and client—that often makes providers uncomfortable because they might simply not know how to go about it (Chinman, Allende, Bailey et al., 1999).

Individual and group supervision, in which recovery guides share their experiences with one another and have an opportunity to give and receive feedback, is a critical venue through which guides can process the range of complex issues that accompany community-based practice. Supervision may include such issues as: 1) how to conduct meetings and interactions in a wide range of settings (e.g., coffee shops, soup kitchens, etc.) in such a way that both the guide and the client feel, and are, reasonably safe, 2) when and how to introduce the client to a social circle that you may already be connected to as a member of the same community (e.g., a religious parish), 3) how to decide when it is appropriate to use your personal resources to assist a client (e.g., using your own vehicle to drive the person to her daughter’s kindergarten graduation when the agency van is not available), or 4) which type of personal information (e.g., the guide’s own disability status) can be shared in the name of establishing and maintaining a genuine and empathic helping relationship. Supervision must address all of these bends in the road of the recovery journey as well as the guide’s *own personal* anxieties about the demands of the trek—especially in light of the fact that traditional training programs do not often adequately prepare providers for this type of work.

Finally, while clinical supervision can be a critical piece in assisting the guide to become comfortable in his or her role as an individual provider, it cannot, in and of itself, address larger, systemic obstacles that might impede recovery. These obstacles include such things as: 1) eligibility or entry criteria that the person must meet in order to be admitted to certain services (e.g., “work readiness” as a criteria for vocational rehabilitation), 2) funding structures that recognize a limited range of clinical interactions as reimbursable services, 3) inadequate community resources (e.g., a lack of affordable housing), 4) excessively high caseload sizes that prevent the development of responsive helping relationships, or 5) entrenched policies and procedures that prohibit such relationships even where caseload sizes would allow them (e.g., a rigid agency policy against accepting gifts from clients). When such obstacles are encountered on an individual’s pathway to recovery, it is the job of the guide to work in

collaboration with the client to identify the roadblock and to find routes under, around, over, or through it. This might mean encouraging the client to challenge the “rules” by becoming active in the agency’s or the system’s various decision-making bodies (e.g., a Policy and Procedures Committee or a Consumer Affairs Council) or becoming active yourself. Where such efforts fail, the recovery guide and the client might even find themselves tempted at times to break the rules to get around the roadblocks described above (Borg & Topor, 2002). Better yet, in proposing the recovery guide as an emerging model of community-based care, we would like to close with the question: “Isn’t it time for new rules altogether?”

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Table 1. Existing Models for Clinical Case Management		
Primary Role of Provider	Principal Theorist(s)	<i>Representative Concepts and Interventions</i>
Detective	Sigmund Freud	<ul style="list-style-type: none"> • Repressed memories and impulses are the primary source of psychological distress and illness, and the uncovering of these memories and impulses is essential to progress and recovery. • The central task of treatment is a focused exploration of past events and early life history and relationships.
Cultural Anthropologist	Carl Jung	<ul style="list-style-type: none"> • The collective unconscious, an inherited set of images and ideas common to all humans, serves as an emotional template, shaping the course of both the individual's intrapsychic and interpersonal life. • Wellness is promoted through an appreciation of trans-generational and cross-cultural common human experiences and an understanding of the current social milieu in which the client lives.
Cheerleader	Carl Rogers	<ul style="list-style-type: none"> • The key ingredient of treatment is the relationship between the therapist and the client where the therapist offers the client "unconditional positive regard" • Unconditional positive regard allows clients to feel accepted for who they are without any labels or conditions, and this acceptance promotes trust in the therapist and creates an environment that enables clients to take risks and to grow (Kensit, 2000).
Coach	B.F. Skinner	<ul style="list-style-type: none"> • Behavior is largely motivated by external rewards and punishments and not by free will. • The behavioral therapist targets current problem behaviors, adopts a directive stance, establishes explicit treatment goals, and determines the reinforcement schedules that are most likely to affect desired change (DeBell & Harless, 1992).
Teacher	Aaron Beck	<ul style="list-style-type: none"> • Affective distress and dysfunctional behavior are due to excessive or distorted ways of thinking about and interpreting one's experiences (Weinrach, 1988). • It is the task of the therapy to identify and restructure these distortions in thinking, often through a series of cognitive exercises and homework assignments in which clients learn to think in a healthier, more rational way.
Police Officer/ Social Control Agent	E. Fuller Torrey	<ul style="list-style-type: none"> • Centralized systems of care in which mental health providers have greater authority to control the lives and treatment of individuals with mental illness are necessary to protect both the individual with the illness and the general public.
(Paid) Friend	Peer Support Movement	<ul style="list-style-type: none"> • Placement of people in recovery in leadership positions in peer support groups, advocacy and education initiatives, and consumer-operated programs and businesses provides positive role-models and instills hope in individuals that recovery is possible for all people.

