Discovering Recovery

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This paper describes the interaction between a micro-history of recovery and a personal recovery history. It begins with a narrative of the author's own recovery experience as he participates in a series of recovery initiatives in a Midwestern state. The impact of these history-graded experiences on his human life-span development is then examined in the context of recovery. Lessons learned are discussed, and some conclusions are drawn. Implications for mental health professionals and people receiving mental health services are also explored. The benefits of getting involved are highlighted, as well as some concerns.

This is a phenomenological study, with all of the caveats, pitfalls and limitations inherent in such an endeavor (Chase, 1996; Clements, 1999; Glynn, 1995; Gottlieb & Lasser, 2001; Lucius-Hoene & Depermann, 2000; O'Dea, 1994; Romanoff, 2001). At the same time, the use of a combination of strategies, including both phenomenological investigation and empirical research, can offer a more complete understanding of people's lives than either approach in isolation (Davidson, 1993; Fredriksson & Eriksson, 2001; Herda, 1999; Lonseth, 1997; Ridgway, 2001; Smythe & Murray, 2000; Stuhlmiller, 2001). Convergent lines of evidence result in more robust theories and models. A hermeneutic dialog between worldviews can be helpful. In such an exchange, the phenomenological approach may generate research foci, hypotheses and methodological strategies for the empiricists, and add a degree of relevance, meaning and practical application to their work.

Part One: My Recovery Story

Sunrise

I woke up at 5:15 AM this morning and left the house by 7:30 AM. Arriving at the Conference Center about an hour later, I parked the car and walked inside. Our brainstorming meeting was scheduled to begin at 9:00 AM.

I sat with the State Director of Mental Health Services, the Quality Enhancement Coordinator for Mental Health, and about a half dozen other policy makers. The purpose of the meeting was to find ways to offer more choices to people living in long-term care facilities, many of whom are quite similar to

people living in the community who are served by mental health centers. Yet they have been offered few viable alternatives to institutionalization. Our goal was to develop strategies to help them identify their strengths and access the resources necessary to rejoin their communities, if they chose to. I was invited to participate because of my work as a recovery studies leader, and member of the State Consumer Advisory Council. I felt good because I was able to contribute some useful ideas that were heard and valued. I felt like a respected colleague.

Before the Dawn

I was past the age of thirty when I first started attending a community support program for people experiencing "severe and persistent mental illnesses." It took a long time and a lot of suffering for me to take that step. Even then, I wasn't completely convinced that my problems were really that "severe" or "persistent." It's funny, in a way, because I was already a survivor of two state mental institutions.

After experiencing a learning disability as a child, I was diagnosed with "ambulatory schizophrenia" when I was seventeen. I didn't believe it, seeing myself instead as a "hopeless romantic." Now I can laugh a little. At least I could have schizophrenia and walk at the same time.

My world was more vivid and poignant, if more painful, than the "humdrum" world. At best, I was a creative impressionist. At worst, I was an awkward misfit. My world sometimes felt like a distorted house of mirrors reflecting infinitely inward upon itself. Somewhere there had to be a more accommodating existence. The search for that existence became the journey of my life, a search for islands of hope in a sea of despair.

I inherited my family's history of hiding what I once thought of as "unmentionable shames." When I was a teenager, my mother broke into tears as she revealed to me that her father had died in a mental institution. His suicide was kept a dark secret. The real cause of his death had to be concealed in order for him to be buried at the church cemetery. The tragedy of my grandfather's death would later give me a strong sense of meaning and purpose for my own life.

Severe symptoms forced me to drop out of high school, but I still tried desperately to "pass for normal." I'd internalized the old stereotypes about mental illnesses. Imagining years of chronic institutionalization, poverty and isolation, I feared losing my identity, hopes and dreams. I wouldn't admit to myself, let alone anyone else, that I experienced severe psychiatric symptoms. I hid them at all costs, even to the point of losing jobs and relationships. I ran away from my own stereotypes. Deep down inside, I stigmatized *myself*.

Opportunity Knocks

I looked across a bulletin board at the community support center I was attending. A brightly colored flyer caught my eye. It read, "Train for a Job Helping People Like Yourself: Peer-Provider Class Forming…" A surge of energy went through me as I read it, then I quickly looked away. I thought to myself, "Is this too good to be true?" I looked back at the two names and phone numbers written at the bottom, and again I looked away.

For years, feelings of brokenness had driven me to strive hard. I tried to outdo everyone and everything, including myself. I did it pretty well at times. I started intensive psychotherapy at the age of sixteen. I got my GED, and then got into college. I started getting A's in all of my courses. It was great for a while, and I dreamed of becoming a successful psychologist. Then it hit me again out of the blue. Odd sensations and overwhelming anxieties immobilized me. My sense of identity disintegrated. Existence itself seemed precarious. I hung on tight and graduated from college, but it took all that I had. The following years had many ups and downs. I finally managed to complete my doctorate in psychology, but the effort to fit in consumed me for years to come.

After desperately trying for so long to pass for "normal," and nearly losing everything, I finally surrendered. I was at square one. My newfound humility was liberating. I allowed myself to become teachable again. It was a starting point in my recovery.

The flyer about the peer-provider class kept coming back into my thoughts. The idea of learning how to help my peers, while being upfront about experiencing severe symptoms, appealed to me. I gathered my courage and made the call. A wonderful opportunity opened up that would radically change my life.

Peer Providers

The University of Kansas, School of Social Welfare has a progressive team at the Office of Mental Health Research and Training, specializing in the Strengths Model of recovery from psychiatric disabilities. In the mid-'90s, they invited Dr. Dan Fisher, a nationally renowned peer-provider and empowerment advocate, to be the keynote speaker at a conference. Dr. Fisher highlighted the benefits of training and hiring peer-providers (Fisher, 1994).

I learned that these benefits appear at many levels. There are benefits to those who receive services, to the peer-providers, to mental health centers, and to the mental health system (Carlson, Rapp, & McDiarmid, 2001). One study found that peer-providers have more face-to-face contact with those they serve than similar professionals (Solomon & Draine, 1996). Another study found more engagement and outreach by peer-providers (Lyons, Cook,

Ruth, Carver, & Slagg, 1996). A two-year follow-up study found that people served by peer and non-peer providers fared equally well in terms of objective outcome measures (Solomon & Draine, 1995a, 1995b). Peer-providers often serve as powerful, positive role models for the people they served (Boykin, 1997; Shepard, 1992). They can help professional staff recognize their own prejudices, and the ways they stigmatize people (Dixon, Krauss, & Lehman, 1994; Miya, Wibur, Crocker, & Compton, 1997). Peer-providers facilitate empathy by other professionals, helping them deal with challenging situations (Francell, 1996). Additionally, role-identification by peer providers can increase their self-esteem and open pathways for personal development (Boykin, 1997; Mowbray & Moxley, 1997).

After hearing Dr. Fisher's presentation, the director of the mental health team said, "Let's do it!" This was the birth of the Kansas "Consumers-as-Providers" training program. Two social workers from the mental health team, and Su Budd, a distinguished consumer-advocate (Zinman, Harp, & Budd, 1987), began a yearlong planning process. Su and one of the social workers then went on to serve as its first instructors. The format was like a college course with an internship component. Each student was assigned a staff member from his or her internship site to serve as a mentor.

When I called about the peer-provider class, I reached Su Budd. She shared a wealth of information with me as she guided me through the application process. If it weren't for her, I may not have gotten through it. Her guidance was pivotal in the transformation of my life. She remains a good friend.

I felt a newfound sense of hope and excitement when I learned that I was accepted into the class. I got there early on the first day, and I met another student who had also come early. She was an older, distinguished looking woman who seemed a little scared. She was very friendly though, and we hit it off right away. I think our shared experience and sense of purpose put us both at ease as the class gathered. The social worker serving as co-instructor was out of breath from carrying course materials when she got to the classroom. She instantly filled the room with her effervescent enthusiasm. Her commitment to the project was inspiring and compelling.

It was apparent that a lot of thoughtful planning went into structuring the training, including the practicum experience. I was assigned to a homeless outreach team at my internship site. My mentor was an experienced outreach specialist. After my orientation, I began my internship by shadowing my mentor. Eventually, with close supervision, I became a recovery facilitator for several people. I attended weekly team meetings and met with my mentor weekly. I also had the good fortune to meet and work with members of S.I.D.E., Inc., a peer-run organization in Kansas City, Kansas. It wasn't long before I joined S.I.D.E. myself. We've worked closely together on many recovery initiatives, and the friendships I've developed there are a great source of support and inspiration.

The learning experience in the peer-provider training centered on the core values and principles of the Strengths Model (Rapp, 1998a) and the recovery paradigm (Anthony, 1993). The more I learned, the more committed I became to these principles. Before I graduated, I applied for a job with the mental health team at the University of Kansas. There was an opening for a Supported Education Specialist to help with subsequent peer-provider classes. Just before graduation, I found out that I had gotten the job. I felt a sense of synchronicity and exhilaration, like a divine intervention had taken place. Finally, I would be doing something that could have great meaning to me (G. T. Deegan, 1992). This is particularly true because of my grandfather's death, which both haunts and inspires my work.

In June 1999, the School of Social Welfare sponsored the first Kansas Recovery Conference. Many pioneers from the recovery movement participated and gave presentations. Round table discussions explored many facets of recovery. This experience was a major step in my recovery, my developing identity, and my sense of connection with others. I began to feel a sense of authenticity that had often eluded me in my work. Finally, there was a niche where the real me could stand for something. The only problem was I found myself over-stimulated. My head was swimming with exciting new ideas, but I wasn't sure where to put them. My heart swelled with emotion and motivation, but I didn't know how to channel them. The growth curve was steep, and it felt overwhelming. Ultimately, I was challenged to integrate many dissonant facets of my life and my personality.

Making a Contribution

I wish I could say that my recovery path was straight and clear from this point onward. It would be a tidy story if it led to such a neat and happy conclusion. I'd been warned that it wouldn't be that simple. My tenure with the mental health team began in the summer of 1999, working on the peer-provider project. I helped design flyers, held informational meetings, and analyzed feedback and evaluations from the first class. I also started an alumni association. We succeeded that summer in our appeal to the Behavioral Sciences Regulatory Board to accept the hiring of peer-providers by the same mental health centers where they were receiving services. This was an important milestone because there are many sparsely populated areas in Kansas. They are

geographically isolated, "frontier" communities where it is nearly impossible to arrange for alternative services.

During this period, I enrolled in a correspondence course on wellness recovery and symptom self-management, focusing on the Wellness Recovery Action Plan, or WRAP (Copeland, 1997). That fall, I attended a WRAP Facilitator Training in Vermont with three of my co-workers. It was wonderful and exciting, but again I felt emotionally overwhelmed.

After a cool autumn walk in the late, Vermont afternoon, I went to dinner with our training group. My thoughts reflected on my mother. I wished she was alive to see all of this. Suddenly my emotions overflowed, and I burst into tears. I wondered how this might affect my new colleagues, but they were understanding and supportive.

Growing Pains

My background in organizational and community psychology helped me understand that emerging into a new leadership role is often a great challenge (Cherniss & Deegan, 2000). Still, I felt a burden on my shoulders to demonstrate my competence. I served as a supported education coach and as a liaison for the internship part of the peer-provider training. I finished the fall training, but I looked forward to a break over the holidays. Symptoms of anxiety, distractibility and irritability began to emerge.

I was told that I could soon take responsibility for WRAP workshops throughout the state of Kansas. I was overjoyed, but again my head was spinning. So much was happening in such a short time. My leadership role was getting ahead of me. I felt awkward, oversensitive and prickly. I noticed my co-workers seemed put-off. It must have been hard for them. It was surely a tough time for me.

The mental health team invited Mary Ellen Copeland, a well known author and educator, to come to Kansas for a Wellness Conference in early February. I shied away from getting involved in the conference planning because of my tendency to get overwhelmed and spacey at that time. I was afraid of getting snowed under, but I think I seemed aloof. I wish I'd communicated more clearly to my co-workers what I was going through.

By the time of the conference, I'd agreed to help in any way I could. Somehow I slipped into the lead role. Over a hundred people came, and things started going wrong. A printer broke down, the microphones didn't work, and books were left behind. Food was cold, drinks were warm, and a toilet began to overflow in a restroom. It seems funny now, but I couldn't see the humor then. I was the one people turned to for solutions, but I experienced them as barking orders at me. I snapped back at them. I still struggle to forgive myself for my shortcomings that day.

The intensity staggered me and I became a wreck. Afraid I might lose my composure completely, I left before lunch, forcing myself to take a "wellness break" for much of the afternoon. If not for my commitment to the work and the respect I had for the mental health team, I might not have come back. When I did return, I wasn't sure I still had a job. After the workshop, I dropped Mary Ellen Copeland off at the airport. I went home in a state of semi-shock.

I got a call that weekend from the director of the mental health team. He said, "I heard the conference was an unequivocal success." I let out a sigh and said, "Yes, I thought so too." Then he asked me to meet with him the next week. As I look back on it, someone else might have said, "I heard the conference was an unequivocal mess!" But he helped me work out a plan of action, and to make amends to my co-workers. He also helped me develop and practice a WRAP plan customized for work.

Soon I became the lead WRAP trainer in the state, and I began training other peer-providers to present workshops. We did WRAP trainings right and left, and I fell in love with the work. It wasn't easy, and there was a lot of travel, but I loved it. We presented over thirty WRAP workshops in Kansas, implemented a follow-through support program, and developed a curriculum to train recovery educators and facilitators. I led a research team studying outcomes for the symptom management training and support programs that we designed. We also developed a workshop on "Spiritual Dimensions in Mental Health Recovery."

Many of the recovery educators and facilitators I trained have demonstrated strength and persistence that continue to inspire me. Several have become well known advocates at the state level. Most are very effective and popular, and one was nominated and recognized by the registry of "Who's Who in America" (Marquis, 2000). I am fortunate that my work has helped me develop a nurturing support network and many lasting friendships.

Recovery Initiatives

The Strengths Model paved the way for mental health reform in Kansas, contributing to the closure of several state hospitals (Chamberlain, Rapp, Ridgway, Lee, & Boezio, 1999; Rapp & Moore, 1995; Rapp & Wintersteen, 1989). The peer-provider training and the first recovery conference took this work to the next level, forging strong, recovery-oriented partnerships. The Department of Social and Rehabilitation Services now oversees and coordinates joint activities between the School of Social Welfare, the Self-Help Network, peer run organizations, and mental health centers across the state. A Mental Health Knowledge Exchange website links these partners with people across the

Table 1—Statewide Recovery Initiatives (2002-2003)

Recovery Education	Mutual Self-Help	Collaborative Efforts Between Professionals and Peers	Advisory Councils
Recovery Educator Training	State-Funded Peer Run Mutual Self-Help Organizations (over 20)	Peer Provider Program	Governor's Mental Health Planning Council
Recovery Facilitator Training	WRAP Support Groups	CMHC Satisfaction Survey	Kansas Consumer Advisory Council for Adult Mental Health, Inc.
Wellness Recovery Workshops Featuring Symptom Self-Management and Relapse Prevention	Other Self-Help Groups Supported by the Self-Help Network	Quarterly Conference Meetings with Peer Run Organizations Facilitated by The Self-Help Network	Kansas Citizen's Committee for Substance Abuse Treatment and Prevention
Recovery Leadership Academy	Recovery Tools Website www.recoverytools.org	Co-Facilitating Training for Mental Health Professionals	Oversight Committees for Various State Initiatives
Annual Recovery Conference	Annual Recovery Conference	Annual Recovery Conference	Annual Recovery Conference Planning Committee

state through the Internet and e-mail contact. This project also provides computers and Internet access to over twenty peer-run, mutual self-help organizations. A State Office of Consumer Affairs and Development facilitates communication between stakeholders, providing information, technical assistance and advocacy. A Mental Health Consumer Advisory Council plays a key role in policy development and program planning. Peer-run organizations conduct a Satisfaction Survey for mental health centers throughout the state. A network of these organizations also meets quarterly. The School of Social Welfare recently began a Strengths Recovery Project to develop and disseminate a strengths-based approach to recovery. Although a complete description of the recovery initiatives in Kansas is beyond the scope of this paper, Table 1 summarizes this growing network of opportunities.

Part Two: Retrospective Analysis

The Right Model at the Right Place and Time

The Strengths Model focuses on helping people discover and use their natural strengths to work toward their own goals (Marty, Rapp, & Carlson, 2001; Rapp, 1998a, 1998b). I could certainly see how this approach had been helpful in my life. The first psychologist I went to as a teenager naturally used this strategy. But, for me, the Strengths Model is much more than a general approach. It is a detailed and specific plan that I use to organize my life. I use it regularly for my own personal strengths assessment, goal planning, resource acquisition, mastery and celebrations. Even this article is a result of my strengths assessment and personal plan.

The Strengths Model makes sense to me theoretically, partly because it resonates with my understanding of biology. Biologists demonstrate that a core characteristic of all life is purposeful, goal-oriented activity (Keeton, Gould, & Gould, 1996). This principle forms the core of the Strengths Model. The model also appealed to me philosophically. Existential philosophy and psychology place the need for meaning and purpose at the heart of the human condition. There are even parallels between the Strengths Model of case management and existential Logo-therapy developed by Victor Frankl (Frankl, 1959). Logo-therapy helps people discover the often hidden meaning and purpose in their lives, and to chart a course toward fulfilling their unique reason for being alive. As even the nihilist Friedrich Wilhelm Nietzsche wrote, "He who has a why to live for can bear almost any how" (Nietzsche & Kaufmann, 2000).

The Angels Are in the Details

My training in cognitive-behavioral psychology helps me understand how the Strengths Model is structured from empirically derived psychological princi-

ples. It translates long-term goals into discrete, measurable tasks with specific timelines. The Strengths Model also encourages rewards and celebrations for the completion of each important task. These detailed steps transform the Strengths Model from a nice philosophy into a very effective organizational framework.

The Strengths model has strong parallels with the positive psychology movement, especially in the psychology of hope (Snyder, 2000). In defining strengths and passions, the Strengths Model develops a strong, positive sense of personal agency for attaining goals. It then organizes goals into specific tasks and timelines, helping to chart a clear pathway to these goals. The Strengths Model also appealed to me because of its comprehensive, holistic nature. Each major life domain, from financial to spiritual, has a place in it.

The Strengths Model has additional roots in Community Psychology (Rappaport & Seidman, 2000). In Strengths case management, the community is viewed as an oasis of natural resources, where social connections are critical. The role of the case manager is to help people discover and utilize these resources to reach their goals and find a fulfilling niche in the ecology of the community (Rapp, 1998b).

One of the core values of the Strengths Model, and also the culture of my workplace, is "client-centered" administration (Rapp & Poertner, 1991). The most important consideration in all of our work is to be of maximum benefit to the people we serve. This philosophy encourages flexibility, innovation and creativity. It also demands humility. It's not always easy, but it's worth the effort.

The Recovery Paradigm

During the peer-provider training, we came to appreciate that people who experience major psychiatric syndromes are much more resilient than myths would have us believe (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a, 1987b). My sensitivity was heightened to the micro-aggressions and spirit breaking practices that frequently occur within the mental health system (P. E. Deegan, 1990). One of the instructors traced the roots of the recovery paradigm (Anthony, 1993; Spaniol & Koehler, 1994; Spaniol, Koehler, & Hutchinson, 1994) back to the psychiatric survivor movement in the early 1970s (Chamberlin, 1978, 1984; Zinman et al., 1987). She explored the significance of mutual self-help and peer run organizations (Chamberlin, Rogers, & Ellison, 1996; Zinman, 1986). We also learned about the benefits and possibilities for people who experience major psychiatric symptoms to work in mental health research and education (Campbell, 1996, 1997; Rogers & Palmer-Erbs, 1994).

Although each individual's recovery path is unique and complex, several recurring themes emerge: 1) reclaiming hope; 2) building a positive sense of identity; 3) distancing one's self from psychiatric labels; 4) managing symptoms; 5) building a strong support system; and 6) finding a sense of meaning and purpose. I saw a natural fit between the recovery paradigm and the Strengths Model.

Recovery in the Context of Life-Span Human Development

(Harding et al., 1987a, 1987b) studied the ability of people diagnosed with schizophrenia to improve significantly over long periods of time. In one long-term study, 269 people from several Vermont state institutions were given a ten-year, comprehensive rehabilitation program that provided a continuity of care from the institution into the community. This longitudinal study found that 62-65% achieved significant improvement, or recovery, across multiple domains including symptom severity, work, social relationships and self-care. Reading this study instilled in me hope that many people can and will improve, and enter into recovery.

In *The Nature of the Child*, Kagen (1984) shows that early childhood experience does not permanently shape our lives to the extent once thought (Freud, 1959). In *Three Seductive Ideas*, Kagen (1998) even casts doubt on the stability of traits, like intelligence, fear, anxiety, and temperament. In the research literature, there has been a growing trend toward recognizing plasticity and resiliency throughout lifespan human development (Craig & Baucum, 1999; Rothi-Gonzalez, 2001; Sigelman & Shaffer, 1998). This capacity for positive, enduring development continues into the later stages of life (Grafman, 2000; Heckhausen, 2001), offering a strong sense of hope and also raising some interesting questions. For example, "What effects can personal and social history have on long-term recovery?" "Can even a modest influence on the micro-history of the recovery movement help create enduring opportunities for others?"

Stein, Fonagy, Ferguson, and Wisman (2000) take an ideographic approach to the study of resilience as they chronicle the dynamic unfolding of lives through time. When studying people over long periods, we begin to recognize the influence of history on human experience and psychological development. Historical events that have a strong impact on the course of one's life and further development are termed "history graded" experiences (Simons & Thomas, 1983). The influence of history-graded experiences depends, of course, on how old we are when they occur (du Toit, 1992). For example, people who went to college during the Viet Nam War developed during a different historical Zeitgeist than those who are in college now. In every culture, historical

events create unique challenges and opportunities (e.g., the American gold rush). Other history-graded experiences are related to a more focused history, such as the recovery movement. Each person's development is shaped by a combination of macro-historical and micro-historical events, as well as personal experiences.

My narrative demonstrates the powerful effect that a micro-history, such as the recovery movement and Kansas recovery initiatives, can have on people's recovery and life-span development. Every small contribution to a micro-history of recovery can thus have a larger, reverberating impact on many people's lives, including the one making the contribution. I have personally experienced a "recovery Zeitgeist," which has greatly impacted my life-span development.

The Benefits of Getting Involved

My recovery and development were increasingly shaped by my growing involvement with recovery initiatives in Kansas. There are benefits and risks to getting involved in any new adventure. If one is willing to take a calculated risk and get involved in making even a small contribution to the history of recovery, that involvement may create new opportunities for personal development. An added benefit of getting involved in the history of recovery is the ability to create opportunities for others as well. I strive to remember the importance of newcomers to recovery, and the opportunities I must create for them, as well as myself. I'm also diligent in my own symptom management and relapse-prevention. I use many of the wellness tools I teach others on a regular basis in my own recovery. These include relaxation and stress reduction techniques, cognitive reframing, sleep management, nurturing my support system, seeking balance in my life, and seeking appropriate professional health care.

Discussion

A major thesis of this article has been to explicate the strong empirical underpinnings of the recovery paradigm that converge with lived experience and existential philosophy. This convergence validates an elegant shift in our collective worldview. As I continue in research, training and practice, I'm reminded to use care to balance, confirm and complement each of these ways of knowing and visions of reality (Messer & Winokur, 1984) on a consistent basis. Such a hermeneutic process will ultimately provide the richest rewards.

Environmental psychologists remind me of the danger of removing research and practice too far from the complexities of real environments and lives (Bechtel & Churchman, 2002). As we continue to shape the "Zeitgeist of recovery," in theory and practice, evidence should be broadly defined to include the many well-established and validated methodologies and perspectives of the social sciences. The lived experience of people in recovery, their narratives, and their creativity should also take a prominent position (Anthony, 2001). Such an approach may steer us toward solutions that are more complex and difficult to prove, but potentially more rewarding. *Broadly defined*, evidence-based practice has a rightful place in the recovery paradigm. Developed and implemented with critical care and concern, recovery principles should be based on converging lines of rigorous evidence. Yet we need to draw on a wide array of interdisciplinary resources and traditions, and leave room for creativity, flexibility and innovation.

Such an approach toward the development of sound recovery principles and practice should deal with emerging questions and concerns. For example:

- Are the positive effects of the recovery movement reaching the majority of people experiencing severe psychiatric symptoms?
- Will the principles of recovery be misused by some to deny desperately needed services to vulnerable individuals, increasing the likelihood they will fall through the cracks?
- Will an oversimplification of the recovery paradigm give way to a "one size fits all" approach?
- Could a reaction to the "celebrity" of the recovery movement cause some to question whether recovery is more myth than reality (Whitwell, 1999)?
- Could such a reaction bring about a return to treating people with severe mental illnesses based on a strict and confining perspective on science and practice?

Future Directions and Next Steps

Evidence suggests that mental health recovery is more than a fad or trend in mental health circles. The newly emerging social history of the recovery movement provides new niches and opportunities, as well as a sense of identity, direction and *hope*. Yet much work still remains. We must remain critical, but not cynical. We should continue to identify and test hypotheses, and leave room for innovation.

People in recovery and the mental health professionals can work together to expand opportunities for recovery. Such a coalition insures that complex, individual needs and goals are not overshadowed by a "one size fits all" approach. Steadfast resolve can ensure that adequate, ongoing supports maximize recovery opportunities for individuals in every circumstance. Can we make recovery a reality for as many people as possible while providing a diverse array of supports for a wide spectrum of needs? If we come close to accomplishing this goal, we will change the course of history ever so slightly.

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