SOCIAL WORKER ATTITUDES TOWARDS RECOVERY AMONG PEOPLE WITH SERIOUS MENTAL ILLNESS

by

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Abstract

Growing numbers of researchers are studying mental health practitioners' adoption of the Recovery Perspective and its operational model, Psychiatric Rehabilitation. However, they have not studied social workers, even though they provide the majority of services to seriously mentally ill consumers (SMI). This study examined social worker's practices, goals, and adoption of the Recovery Perspective and Psychiatric Rehabilitation. From a random sample of 3,000 National Association of Social Work (NASW) New York State members, 441 completed paper and pencil surveys that included two measures, the *Recovery Knowledge Inventory* (Bedregal, Davidson & O'Connell, 2006) and the *Psychiatric Rehabilitation: Beliefs, Goals and Practices Scale*, (Casper & Oursler, 2003). The majority of subjects (67%) worked with SMIs for over ten years. Only 21% reported employment in restrictive settings including in-patient, day hospital, or continuing day treatment; over 100% reported primary or secondary employment in less restrictive settings including clinics, private practice, or other. Sixty-one percent had a close friend or family member with SMI. Pluralities reported subscribing to a psychodynamic (42%) or cognitive-behavioral (47%) theoretical frame of reference.

I found a high level of positive response consistent with the Psychiatric Rehabilitation and Recovery Perspectives. Those who selected "Other" as their theoretical framework endorsed the models more than those who selected "Psycho-dynamic." Private practitioners were less likely to endorse the models; those working in Continuing Day Treatment Program were more likely to endorse them. Sub-scales in the two instruments suggested that New York State NASW social workers embraced the ideals of both models, but were less likely to practice in recovery-oriented ways.

In New York State, social workers adhere to model's ideals, but may not practice according to their principles. Those more inclined to practice from these principles were not in mainstream treatment roles, but employed approaches that are more flexible. Social workers in clinics, where New York State promotes this type of treatment, were least likely to practice this way. Implications for social work education are profound, since schools are the locus of professional preparation. Particularly since younger workers were less likely to endorse the models, current educational practices appear inconsistent with regulatory regulations.

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CHAPTER I. INTRODUCTION AND PROBLEM FORMULATION

Introduction: Defining Serious and Persistent Mental Illness

Considerable ambiguity exists regarding what constitutes serious mental illness (SMI). Diagnoses that fit into the SMI category include schizophrenia, bi-polar disorder, major depressive disorder, anxiety disorders, and in some cases, borderline personality disorder. However when Parabiaghi and colleagues (2006) studied the prevalence of SMI, they asserted that an assessment of duration of symptoms and the level of dysfunction a person experienced determined whether an individual suffered from serious and persistent mental illness or not. In their formulation, a diagnosis alone did not indicate serious mental illness (Parabiaghi, Bonetto, Ruggeri, Lasalvia, & Leese, 2006).

Currently, in New York State, the Office of Mental Health considers various factors to determine serious mental illness in an adult. A person must be age 18 or older with a diagnosable mental, behavioral, or emotional disorder that meets diagnostic criteria specified in the DSM-IV. In addition, the condition must result in functional impairment that considerably interferes with or restricts one or more major life activities. These might include the ability to maintain steady employment, care for one's own home, secure public benefits without assistance, or sustain oneself outside a hospital setting (http://www.omh.state.ny.us/omhweb/pcs/portal/faq.html). However, a SMI diagnosis does not include alcohol or drug disorders, organic brain syndromes, developmental disabilities, or social conditions. Additionally, in New York State, a person with SMI must meet one of the three following criteria: they must be SSI or SSDI-eligible due to mental illness; experience long-term impairment in functioning due to mental illness; or experience recurrent problems with concentration, perseverance, or ability to complete tasks in a timely manner.

According to the New York State definition, people with SMI must have experienced functional limitations because of mental illness for 12 months on an unremitting or intermittent basis. They may have significant difficulties in self-care, such as problems with hygiene, nutrition and attire, being self protective, obtaining health care, or adhering to medical advice. They may also exhibit restriction of activities of daily living that result in difficulties maintaining a home, using transportation, managing money, or accessing community services. In terms of social relationships, people with SMI have difficulty establishing and maintaining friendshhips; ineffective interpersonal interactions impede getting their needs met, maintaining relationships, and maintaining self-respect (Linehan, 1994). Deficiencies in social skills, compliance with social norms, or inappropriate use of leisure time may also be apparent. It is not necessary that a person exhibit these problems at all times, rather he or she may have a documented history that demonstrates they met these criteria in the past. A person with a SMI diagnosis may be currently well functioning, on psychotropic medication, in psychiatric rehabilitation, or other support may be controlling their symptoms (http://www.omh.state.ny.us/omhweb/pcs/portal/faq.html).

The Impact of Mental Illness on Society

Prevalence rates of mental illness in the US are staggering. An estimated 26.2 % of Americans 18 years and older suffer from a diagnosable mental disorder in a given year. That is, one in four adults, or 57.7 million Americans over the age of 18. Approximately 6 %, or one in 17 people, who suffer from serious mental illness, confront serious challenges. Mental disorders are the leading cause of disability in the US and Canada for people ages 15 through 44. Many suffer from more than one mental disorder at a given time. In fact, nearly half (45%) of those with any mental disorder meet criteria for two or more disorders, and severity is strongly related

to multiple diagnoses (http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml).

Both the National Institute of Mental Health (NIMH) and the National Allicance on Mental Illness (NAMI) track the prevelance of mental illness in the US. Approximately 2.4 million Americans or 1.1% of the population lives with schizophrenia. Bi-polar disorder affects 2.6 % and major depression 6.7% of the adult population. Major depression is the leading cause of disability in young people (NAMI, 2006). Anxiety disorders, which include panic disorder, phobias, obsessive-compulsive disorders, posttraumatic stress disorder, and generalized anxiety disorder are present in 18% of adults. Co-occurring mental health and addiction disorders occur in approximately 5.2 million individuals (http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml). New York State has 14,544,281 residents. Of this resident population, 785,391, or 5.4%, suffer from a serious mental illness. The lower limit of this estimate is 538,138, or 3.7%. The upper limit estimate is at 1,032,644, or 7.1% (http://mentalhealth.samhsa.gov/databases/databases_exe.asp?D1=&Type=ASMI&Myassign=list).

The typical age of onset of a serious mental illness is between 14 and 24 years. Although some research suggests that early treatment is more effective (Lieberman & Kopelowicz, 2002), and there are many treatments available, it is often long after onset that people access care. Less than one-third of adults with mental health needs receive care in a given year (NAMI, 2006). People of color and ethnic minorities are less likely to seek mental health care, and when they do, they often receive poorer quality care than White people do (NAMI, 2006; New Freedom Commission on Mental Health, 2003).

Serious mental illness can predict poor social, medical, and financial outcomes. Individuals with SMI are at higher risk for serious medical problems. Adults with SMI die an average of 25 years earlier than the rest of the population, frequently due to treatable medical conditions (Davidson, Raakfedlt, & Strauss, 2010). Furthermore, suicide is the 11th leading cause of death in America, and at least 90% of people who commit suicide have a diagnosable mental disorder (NAMI, 2006). The consequences of untreated serious mental illness include the inability to remain employed, substance abuse, homelessness, incarceration, suicide, and unfortunate lives. Over half of high school students 14 and older diagnosed with mental illness neglect to complete high school. This is greater than the drop out rate for any other disability (NAMI, 2006).

Mental illness has an enormous effect on health and productivity in the US and globally. The Global Burden of Disease study conducted by the World Health Organization, the World Bank, and Harvard University found that mental illness, and associated suicide, accounted for over 15% of the burden of disease in established market economies such as the US. This constitutes a greater burden than that caused by all cancers (http://www.nimh.nih.gov/health/topics/statistics/index.shtml).

The economic costs of mental illness are weighty. In the US, the indirect cost to society is approximately $79 billion dollars. The bulk of that amount, $63 billion, is due to the loss of productivity related to the illness. Indirect costs refer to decrease or loss of productivity among adults who would otherwise contribute to the workforce and direct costs refer to the direct medical expenses such as care, treatment, and rehabilitation (http://www.surgeongeneral.gov/library/mentalhealth/home.html#topper). In the 1990s, care for schizophrenia alone cost $15 billion dollars, and by 1996, the US spent more than $99 billion for

the direct treatment for all mental illness. This included substance abuse and Alzheimer's disease (http://www.surgeongeneral.gov/library/mentalhealth/home.html#topper; Turner-Crowson & Wallcraft, 2002).

The History of Mental Health Reform Movements in the United States

Historically, society shunned, discriminated against, or ignored people with mental illness and viewed them as incapable of making decisions themselves. However, beginning in the 19th century, several waves of reform created shifts in societal views of people with mental illness. Grob (1994) chronicled four such shifts in the care and attitude toward the mentally ill in the United States.

The first wave of reform was moral treatment and took place in the early to mid-1800s in asylum settings that promoted compassionate and restorative treatment. In the 1890s, the mental hygiene movement resulted in the establishment of mental hospitals or clinics. This reform was an effort to prevent mental illness and provide a more scientific approach to treatment. A third major shift took place between 1955 and 1970. Known as the community mental health movement, treatment took place in community mental health centers. This was the result of the de-institutionalization of people with mental illness; it led to community integration. Finally, in 1975 a reform towards community support took hold. It was different from the community mental health movement, because it focused on mental illness as a social welfare problem and addressed the lack of adequate housing, employment opportunities, and integration into the wider community (Grob, 1994; Wanchek, McGarvey, Leon-Verdin, & Bonnie, 2011). This latest reform is consistent with the recovery perspective, which is central to the research I conducted for this dissertation.

The Recovery Movement: Hope and Meaning

Throughout history, people with mental illness have recovered and documented their recoveries, often in personal memoirs that described their experiences with the mental health system (Davidson, 2005). For example, Clifford Beers (1935) wrote about his recovery, and Paul Schreber (1955) produced a similar memoir about his experiences. These and other individuals wrote from a perspective of personal triumph, but not until the 1980s did increasing numbers of people recovering from serious mental illness begin to reveal the abuses they experienced in the mental health system and tell their recovery stories (Davidson, 2005).

As a group, these individuals became a major force in transforming the mental health system. People with severe mental illness have had a formidable social and political impact; now they sit on boards of directors of most major mental health facilities (Davidson, 2005). Currently, some states require consumer involvement in treatment systems. By the 1990s, society took people with serious mental illness, such as schizophrenia, bi-polar disorder, or severe depression seriously. Individuals who wrote about and advocated for the rights of consumers of the mental health system are proponents of the Recovery Perspective.

In 1999, the Surgeon General issued a declaration that all mental health agencies should be recovery-oriented (Turner-Crowson & Wallcraft, 2002). The Recovery Perspective represented a dynamic shift in how professionals and consumers viewed mental illness and recovery. Building on the work of Americans with disabilities, the slogan "Nothing about us without us," was a major rallying cry of the movement (Davidson, 2005). Rather than being acted upon, recovery-oriented consumers wanted to be equal partners in determining their course of treatment. Even the way in which recovery-oriented individuals defined "recovery" was

different from the traditional view of mental illness and recovery embedded in the medical model.

Rather than looking at recovery as a cure, reduction in symptoms, or a return to social role functioning, which characterizes the medical definition of "recovery," recovery-oriented treatment involves three key concepts: hope, meaning, and getting on with life (Fukui, Stamino, Susana, Davidson, Cook, Rapp, & Gowdy, 2011; Noordsy, Torrey, Mueser, Mead, O'Keefe, & Fox, 2002). The Recovery Perspective was a paradigm shift that transformed the conceptual definition of recovery. It integrated key concepts of living, such as maintaining a sense of hope and taking personal responsibility for recovery (Noordsy, et al., 2002). These concepts are central to the recovery perspective elaborated below.

The recovery literature frequently references hope (Davidson, 2005; Deegan, 1988; Fukui et al., 2011; Noordsy et al., 2002; Turner-Crowson & Wallcraft, 2002). Many consumers have said that professionals told them they had a very poor prognosis. They report being told they could not have a "normal" life (Tooth, Kalyanasundaram, Glover, & Momenzadah., 2003, p.72). Chronic and debilitating illness can lead to feelings of hopelessness, especially when people are confronted with stigma, are left out of opportunities to participate in age appropriate roles, and are relegated to the fringes of society. Even benevolent pressure placed on people to participate in treatment can emphasize illness, and thus perpetuate the perception that there is no hope (Fuller Torrey, 2006; Noordsy et al., 2002). In the recovery paradigm, instilling a sense of hope is imperative for recovery from mental illness. Hope is a necessary factor in motivation, motivation is a necessary factor in taking action, and action is necessary for recovery (Deegan, 1988; Noordsy et al., 2002; Tooth et al., 2003).

Psycho-education is an important part of treatment in the recovery-oriented model; it involves people with serious mental illness learning about their illness and taking responsibility for their own care. Noordsy and colleagues (2002) suggest the paradox of mental illness is that when someone acknowledges that they have it, it reduces the power it has over their lives. Likewise, taking personal responsibility for illness management leads to a more realistic sense of self and may lead to the motivation to do the arduous work of psychotherapy and skills building (Noordsy et al., 2002). Psycho-education helps people with mental illness identify triggers for potential relapse, learn effective coping skills, and build a lifestyle that supports wellness (Turner-Crowson & Wallcraft, 2002).

Getting on with life beyond illness is another key element of the Recovery Perspective. Consumers in focus groups have stated unequivocally that encouragement to get on with their lives beyond their illness is the professional attitude most helpful in promoting their recovery (Legere, 2007; Mead & Copeland, 2000; Noordsy et al., 2002; Tooth et al., 2003). They have identified the importance of help to gain skills of daily living. This aspect of recovery-oriented treatment reflects the extent to which the person is able to assume healthy adult roles outside of the mental health system. This type of treatment represents a shift from the sick role to identifying ones' self through diverse social roles in much the same way as individuals without mental illness do. Meaningful roles allow a person to identify as a full member of society rather than a person on the outside. Roles can include parent, sibling, writer, artist, religious person, friend, actor, leader, or student. Noordsy and colleagues (2002) call these critical components of self-definition beyond one's illness. Mutually supportive relationships are a basic goal of recovery, and relationships with people outside of the mental health system are of utmost importance (Davidson, 2005; Legere, 2007; Noordsy et al., 2002 Tooth et al., 2003).

Getting on with life includes participation in the workforce and other meaningful structured activities (Davidson, 2005; Noordsy et al., 2002). Meaningful activities provide the motivation to take care of one's self and manage the illness (Andreasen, Oades, & Caputi, 2003; Davidson, 2005; Noordsy et al., 2002; Tooth et al., 2003). Recreation complements meaningful work. People with severe and persistent mental illness often feel they are not entitled to the "fun" of leisure activities, vacations, and entertainment. As they begin to integrate into society, they increasingly view these activities as appropriate. Purposely creating opportunities for fun is an indication of hope and optimism.

Psychiatric Rehabilitation

"Recovery" is a concept achieved with the approaches and strategies of Psychiatric Rehabilitation practice (Davidson, Raakfeldt, & Strauss, 2010). This model emerged as a response to the question of how mental health workers should help individuals with severe psychiatric disorders achieve a satisfying life (Farkas, Anthony, & Cohen, 1989). It is a model of care for individuals with severe mental illness. The public policy of de-institutionalization was an attempt to help psychiatric patients achieve satisfaction through lives integrated into the community. However, individuals left institutional care and ended up in communities poorly equipped to provide recovery-oriented care. De-institutionalization had flaws because the political and economic circumstances of the 1970s and 1980s did not fully support the ongoing bio-psycho-social needs of people with mental illness in the community. People with serious mental illness should have benefited from a policy of release from in-patient care (Farkas et al., 1989). Instead, they experienced deprivation in the very communities that were supposed to serve them. This occurred through lack of consistent, comprehensive services, adequate housing,

social support systems, and public education to decrease stigmatization (Farkas et al., 1989; Flannery, Adams, & O'Connor, 2011; Lieberman & Kopelowicz, 2002).

Psychiatric Rehabilitation developed because professionals and consumers identified a lack of viable support for people with mental illness in the community and sought a treatment approach that could provide that support. The model calls for helping people increase their ability to function, so they become more satisfied and successful in the environment of their choice. It promotes the least amount of ongoing professional intervention; the primary methods for achieving sucessful life in the community are through development of client skills and environmental supports.

Traditionally, mental health treatment focused on minimizing symptoms and alleviating sickness, and this reflected mental health worker's perceptions of their roles. Turner-Crowson and Wallcraft (2002) argue that while logic would suggest that if something is broken or sick it can improve, in the field of mental health the historical emphasis was on maintenance rather than recovery. Although diagnosis offers some direction for treatment and care, the fact of a diagnosis of mental illness may have actually harmed peoples' ability to survive successfully in the world. The essential difference between treatment as usual and the Psychiatric Rehabilitation model is that the latter focuses on maximizing health and envisioning the potential of those carrying the diagnoses of serious mental illnesses (Farkas et al., 1989; Turner-Crowson & Wallcraft, 2002). Minimizing symptoms does not necessarily lead to increased functioning. For example, Farkas and colleagues (1989) suggest this does not always result in acquiring the skills necessary to perform in the competitive job market, particularly if the person never had those skills in the first instance. Further, there is no reason to believe that symptoms in and of themselves should be a

deterrent to a successful outcome on the competitive market, particularly with appropriate supports in place (Drake, 2011).

In summary, Psychiatric Rehabilitation rests on two intervention strategies: first, promoting development of client skills and second, the development of environmental resources to support the client. Inherent in this approach is the idea that social workers and other mental health workers can help a person with a psychiatric disability change their current skill levels by promoting environmental supports. It is also necessary to enhance career development, because 70% of people diagnosed with SMI state that their primary goal is to work, and only 10% are actually working (Anthony, 2011; Drake, 2011; & Nygren, Markstrom, Svensson, Hansson, & Sandlund, 2011). These interventions help a person perform the activities necessary to succeed in roles of their own choosing (Farkas et al., 1989).

Social Work, Psychiatric Rehabilitation, and Recovery

Although social work values and ethical principles are broadly consistent with Psychiatric Rehabilitation and the Recovery Perspective, certain core aspects are particularly synergistic. These values include service, social justice, dignity, worth of a person, importance of human relationships, competence, self determination, and cultural competence (http://www.naswdc.org/pubs/code/code.asp; Buckles, Brewer, Kerecman, Mildred, Ellis & Ryan, 2008). These commonalities suggest that social workers would embrace a recovery perspective in their practice with SMI consumers.

Service is an ethical principle in social work. Social workers must make services available to people in need regardless of ability to pay. In practical terms, this could mean providing services *pro bono* to some clients (http://www.naswdc.org/pubs/code/code.asp). This principle parallels the notion of comprehensive, continuous, and consistent services for all people

with serious mental illness that psychiatric rehabilitation promotes. Psychiatric Rehabilitation and the Recovery Perspective call for meeting the needs of the underserved and seeking to provide for both the practical and psychological well being of consumers with serious mental illness.

Social justice is an ethical principle in both social work and Psychiatric Rehabilitation. Social workers challenge social injustices (http://www.naswdc.org/pubs/code/code.asp). Psychiatric rehabilitation focuses on the real world, environmental modification, and community integration. It seeks to level the playing field so people with serious mental illness can live, work, and play in the communities of their choosing as equal members of society and not relegated to its fringes (Anthony, 2004).

Social work recognizes the dignity and worth of the individual (http://www.naswdc.org/pubs/code/code.asp). Similarly, both Psychiatric Rehabilitation and the Recovery Perspective recognize the rights, dignity, and value of all people with serious mental illness. Psychiatric Rehabilitation and the Recovery Perspective recognize a consumer's right to determine their own plan for treatment even if this precludes professional involvement. Self-determination, another ethical principle of social work practice, is a driving force in Psychiatric Rehabilitation (Buckles et al., 2008). Historically, social work has recognized the importance of human relationships in healing and recovery (http://www.naswdc.org/pubs/code/code.asp). This is another Psychiatric Rehabilitation and recovery principle. Relationships, particularly relationships with people outside the mental health system are an integral factor in recovery from serious mental illness. Many parallels exist between social work values and principles of Psychiatric Rehabilitation and the Recovery Perspective that suggests high liklihood social workers would endorse a recovery-oriented practice.

The Social Worker's Role in Mental Health Treatment

Social work mental health providers have seen mental health treatment undergo many changes in the past century. Psychoanalysis, milieu therapies, family and group therapies, and crisis intervention are some of the roles, responsibilities, and theoretical frameworks mental health social workers have had to navigate (Kirk, 2005). During this period, the pendulum of mental health treatment shifted back and forth between psychosocial and biological perspectives. The 1960s, notable for an emphasis on human rights, moved psychiatric patients away from large hospitals that mainly provided custodial care and towards a community-based system of care influenced by the psychosocial model. Recognition of the psychosocial dimensions of mental illness and the need for skills building and environmental supports were possible because of new and transformative medications that enabled many individuals with serious mental illness to function outside of psychiatric hospitals, some for the first time in their adult lives.

In the 1960s, social work as a field supported the dominant mental health system. In contemplating the reasons, early in the twentieth century, Freudian theory was rising in popularity, and the purpose of the casework method of "friendly visiting" changed. Initially, "friendly visitors" investigated applicants for assistance, determined whether they were worthy or unworthy poor, and imparted moral values. Later, the view of social casework shifted to that of a therapeutic relationship (Kirk, 2005).

In the mid 20th century, there was a trend toward more scientific basis for social work interventions. Social workers who wanted to assert their professional status embraced this trend. They adopted the medical model and technical skills based on learning and theory to advance their professional identity. Medical learning guided diagnosis, which guided treatment. Thus,

medicine, particularly psychiatry, became the primary point of reference that social workers used in their search for professionalization (Schulman, 2005).

At the same time, psychiatry began to take a more critical view of the existing mental health system and began shifting in a direction congruent with social work values. Community minded psychiatrists began moving psychiatric patients out of asylums and into the community. Some psychiatrists altered their view from from a medical model of mental health treatment towards a more social and environmental perpective. This resulted in a mutual vision shared by social workers and psychiatrists. However, social workers began studying medical model theories of personality at the expense of person-in-environment problems. This interfered with social work's charge to advance societal change and address problems of mass deprivation. Ironically, as the roles and responsibilities of social workers and psychiatrists began to coincide, this threatened social work's professional elevation. If social workers and psychiatrists were performing the same tasks, the only thing that differentiated them was social workers less education and training (Kirk, 2005) and that they could not prescribe medications.

Problems began to arise in the 1990s when psychiatry shifted towards a bio-psychiatric orientation. Those with an interest in the healing power of the relationship were no longer in the majority (Kirk, 2005). In fact, Fuller Torrey (2006), an influential psychiatrist, advocate, and tracker of mental health statistics, stated that treating serious mental illness such as schizophrenia with psychotherapy was akin to malpractice.

Under President George H. Walker Bush, NIMH declared the period of the1980s through the 1990s as the "decade of the brain." A paradigm shift was occurring in psychiatry that minimized the relevance of a psychosocial model that viewed mental illness as stemming from defective parenting and other childhood experiences. Instead, psychiatrists began to adopt a

neurobiological model that viewed mental illness as a brain disease (Fuller Torrey, 2006). Davidson (2006) suggests this helped decrease stigma, because if mental illness was biological, it was a "no-fault disease." In addition, some were optimistic a biological disorder was curable. This position helped enforce a narrow definition of "recovery" among physicians associated with symptom reduction or cessation (Davidson, 2005).

Social workers provide more services to people diagnosed with mental disorders than any other professionals do, including psychiatrists, psychologists, and psychiatric nurses. In addition, they serve in a range of roles including front line therapists and case managers, supervisors, clinical directors, and commissioners of state mental health departments (Kirk, 2005). Although they may have strong perspectives on current trends in mental health treatment, at this time it is unknown whether they in fact embrace and practice from a recovery perspective. With the resurgence of the medical model, it is unclear whether social workers support a Recovery Perspective or practice from a Psychiatric Rehabilitation model.

The Recovery Perspective and the Shifting Role of the Professional

In the Recovery Perspective, there is a vast difference in the assignment of "expert" status. Professionals are not "all-knowing" keepers of reality. Instead, patients themselves are able to share expertise with one another and gain recognition as experts about major mental illness. Consequently, the psychiatric recovery literature describes professionals as companions or fellow travelers rather than experts (Davidson, 2005). For example, Davidson (2006) proposes changing the nomenclature from case manager to recovery guide, a subtle but powerful shift. It suggests moving from "caring for" to encouraging people with mental illness to become self-managing and partners in their care. It rejects a hierarchical relationship between mental health professionals and consumers (Davidson, 2005). Some professionals find this shift in control

difficult to accept, especially in the context of a litigious, blaming, risk-averse culture. Davidson (2005) does not suggest that professionals abdicate responsibility or abandon their patients. Instead, she is seeking a way of working with people with mental illness that fully respects and builds on their strengths. At the same time as the Recovery Perspective has developed, consumers have advocated for more choice in determining their course of treatment.

The emphasis on evidence-based practices (EBP) in health and mental health treatment developed concurrently with psychiatric rehabilitation. The 1990s engendered considerable optimism, because increased neuropsychiatric research led to understanding mental illness and approaches to treatment in new ways (Frese, Stanley, Kress & Vogel-Scibilia, 2001). Understanding the biological basis of mental illness reinforced evidence-based practice approaches for treating mental illness (Frese et al., 2001). Proponents of evidence-based practices are sanguine regarding recovery as a possible outcome of serious mental illness such as schizophrenia. Therefore, recovery is an important treatment outcome for those who promote EBP among people with serious mental illness. However, the definition of recovery in this context may focus on symptom reduction rather than on a patient's self-determination of wellbeing.

Consequently, the Substance Abuse and Mental Health Services Administration (SAMHSA) initiated research to identify evidence-based treatment for individuals with severe mental illness, and their treatments are consistent with a recovery-oriented approach. SAMHSA's identification of specific evidence-based treatments is shaping a new generation of mental health providers. Reimbursement formulas strongly influence agencies to treat SMI with treatments such as Illness Management and Recovery (IMR), Family Psycho-education, Integrated Dual Diagnosis Treatment, and Assertive Community Outreach Teams (ACT Teams)

(SAMHSA, 2007). Currently, some of these practices reach mental health workers in the form of "tool kits." Their purpose is to effect recovery among people with serious mental illness, although some proponents of the recovery movement are skeptical that EBP supports a recovery-oriented approach. They consider it more consistent with a medical model than the consumer-driven Recovery Perspective.

Statement of the Research

Social worker attitudes towards recovery are an important factor in patient outcomes (Tooth et al., 2003). Their perceptions influence the ability of people with serious mental illness to sustain productive lives (Caughey, 2011; Mead &Copeland, 2000; Russinova, Rogers, Ellison, Lyass, 2011; Tooth et al., 2003). There is consensus that stigmatizing attitudes towards the mentally ill deter help seeking and have an adverse effect on treatment outcomes (Fernando, Deane & McLeod, 2010). As such, there is increased interest in understanding both professional and lay attitudes toward the mentally ill. Researchers have studied public attitudes toward recovery among people with mental illness (Chui & Chan, 2007; Mehta, Kassam, Leese, Butler, & Thornicroft, 2009; & Putman, 2008) and even elementary school student attitudes (Pitre, Stewart, Adams, Bedard & Landry, 2007). As for professionals, recent studies have examined attitudes of occupational therapy students (Beltran, Scanlan, Hancock & Luckett, 2007), doctors and medical undergraduates (Arvaniti, Samakouri, Kalamara, Bochtsou, Bikos & Lividitis, 2009; & Fernando et al., 2010;), nurses and nursing students (Ross & Goldner, 2009; Schaefer, Wood & Williams, 2010; & Yamauchi, Semba, Sudo, Takahashi, Nakamura, Yoshimusa, et al., 2010), and ward attendants (Vibha, Saddiccha & Kumer, 2008). Researchers lead by Casper (2002, 2005 & 2005a) have studied attitudes of psychiatric rehabilitation therapists about recovery, and they have developed measurements for this purpose. Others have studied unspecified health

professionals regarding their attitudes towards Psychiatric Rehabilitation and recovery (Markstrom, et al., 2009). However, social workers are notably absent from this growing body of knowledge, despite the fact that they provide the majority of services to the seriously mentally ill population. The purpose of this dissertation was to begin to fill that gap in the literature.

The existing research about attitudes towards psychiatric rehabilitation and recovery indicates continuing and pervasive pessimism regarding recovery among mental health workers. Because social workers are the most significant group of community mental health providers, it is important to learn more about their attitudes about the capacity for recovery for people with serious mental illness. Their attitudes towards the Recovery Perspective and Psychiatric Rehabilitation may or may not be consistent with those of the groups already studied. Similarly, their knowledge and practices may or may not reflect those of other professional groups. However, learning their attitudes, knowledge, and practices related to these important trends in care for SMI has important implications for the educational preparation of this professional group.

The problem addressed in this study was the limited research about the attitudes of social workers about Psychiatric Rehabilitation for people with severe mental illness and the level of their acceptance of the Recovery Perspective. Current knowledge does not indicate how they define recovery or the influence the current emphasis on the Recovery Perspective has on their practice. This dissertation examined the extent to which social workers adopted a Recovery Perspective and what factors influenced their acceptance or dismissal of the paradigm. It sought to answer a variety of questions: did social workers practice from a recovery-oriented perspective with higher functioning consumers or those who were free of positive symptoms? Did they embrace this model at all times regardless of the consumer's level of functioning or

symptomotology? How much did they know about Psychiatric Rehabilitation and the Recovery Perspective?

This dissertation sought to understand social workers' beliefs, goals, and practices regarding both Psychiatric Rehabilitation and the Recovery Perspective through a paper and pencil survey of a random sample of National Association of Social Workers in New York State who self identified as people working in mental health. I employed two existing quantitative instruments for the survey. The first was the *Psychiatric Rehabilitation Beliefs, Goals and Practices Scale* (Casper, 2003), and the second was the *Recovery Knowledge Inventory* (Bedregal, O'Connell, & Davidson, 2006). They measured adoption of psychiatric rehabilitation and recovery knowledge, respectively. In both cases, the developers tested these instruments for reliability and validity (Casper, Oursler, & Schmidt 2002; Bedregal, O'Connell & Davidson, 2006). Finally, I collected data about the characteristics of the study subjects, particularly if they had a close friend or family member with serious mental illness.

In summary defining trends in the field of mental health occurred over the last 35 years. There has been a burgeoning of scientific research on the relationship between the brain and behavior. In addition, this period saw the introduction of new and empirically supported treatments for mental illness through EBPs; dramatic changes in where mental health care occurs, and the emergence of a strong consumer and family movement with a new definition of recovery from mental illness. These trends raised important questions about the changing role of the mental health practitioners, and social workers in particular. The chapter that follows provides an overview of the history and policy that has informed professional understanding of mental illness.

CHAPTER II: REVIEW OF THE HISTORICAL AND POLICY LITERATURE

Introduction: Historical Treatment of People with Mental Illness

Psychiatry as a discipline did not exist prior to the end of the eighteenth century (Shorter, 1997), and psychiatric facilities were not available to care for people afflicted with madness. Nevertheless, beliefs about the origins of mental illness existed from ancient times, and there were physicians and philosophers who occupied themselves with the problem (Shorter, 1997). In ancient Greece, philosophers sought biological remedies based on the philosophy of the day. For example, Aristotle identified four liquids in the body called humors. He believed that if the amount of any one humor were too great or too small, various conditions, including mental illness, would result. However, in antiquity, most people attributed madness to the whimsical behavior of the gods. The ancient Romans thought that sin or witchcraft caused mental disorders. Later, doctors employed bloodletting, purgation, and dunking as cures for such maladies (Conrad, 1992; & Shorter, 1997). At the same time, there were social or religious explanations for mental illness. Heinous behavior towards the mentally ill ensued from these beliefs including stoning and burning mentally ill people at the stake (Conrad, 1992).

By the beginning of the 19th century, people believed that the cause of lunacy related to the phases of the moon. The treatment of people with mental illness remained punitive and even deadly. Left to the ministries of family and community, horror stories abounded about their treatment. The following passage describes an incident in 1817 Ireland: “When strong man or woman gets the complaint, the only way they have to manage is by making a hole in the floor of the cabin, not high enough for the person to stand up in, with a crib over it to prevent his getting up. This hole is about five foot deep and they give the wretched being his food there, and there he generally dies” (Shorter, 1997, p. 1).

History of Mental Health Treatment in the US

The historian, Grob (1994) chronicled mental health treatment in a series of landmark books. In addition, Conrad (1992), Gerhart (1990), and Shorter (1997) added to the history of mental health treatment in the US and in Western European countries. The work of these authors presents a picture of dynamic changes in the treatment of people with mental illness over time.

During the Colonial settlement of the US, families cared for persons with serious mental illness. At this time, the community did not consider mental illness a social problem (Gerhart, 1990). Families and individuals who settled in America were required to be self-sufficient and expected to care for their own family members in spite of any maladies, age, or disability. Although an individual with mental illness may have exhibited behaviors that caused distress to their family, neighbors, who usually lived far away, were not affected. Mental illness was not labeled as such; those who displayed symptoms that would meet the criteria for a Diagnostic and Statistical Manual IV-TR diagnosis today were simply referred to as lunatics, idiots, or distracted persons (Gerhart, 1990). As the population increased and populations of cities grew, mentally ill people became more noticeable and their behaviors became a problem for society (Gerhart, 1990). Families who were struggling for resources were less able to provide for the ill, aged, and disabled; they looked to their communities for assistance (Conrad, 1992; Gerhart, 1990), and in some colonies, laws made that assistance available.

Asylum Cure

Self-sufficient communities in colonies such as Massachusetts, Connecticut, and New Jersey took responsibility for caring for their most vulnerable members, including people with mental illness. In 1641, the colony of Massachusetts enacted a legal code that provided financially for those with mental illness deemed fit to live in the community. People too unstable

to live in the community were confined in already established alms and poorhouses (Gerhart, 1990).

The poor treatment of inmates of these alms-poorhouses was well recognized. These societies held hard work and autonomy in high esteem. People who could not work were regarded as worthless and treated as such. Individuals who operated these facilities used callous and punitive measures. They provided little food or heat in the winter months and forced people fit to work to function as unpaid labor. Those who engendered particularly negative responses found themselves chained, beaten, or isolated in dungeons. It was common for the almshouse to banish an inmate from the community with no provision for food, money, or clothing. It is possible that many died from malnourishment, illness, or exposure to the elements (Gerhart, 1990).

The Pennsylvania Hospital, established in 1751, treated those who were sick and mentally ill. Their treatment was horrific. Cells were dark and damp, and patients were frequently restrained in straight jackets and restraining chairs. Treatment included bloodletting, searing, emetics, and hot and cold baths. Some patients viewed escape as preferable to this dismal existence, and many did escape (Gerhart, 1990), although again, they were unlikely to survive outside of the institution.

During the eighteenth century, while care for the ill, elderly, and disabled poor was atrocious, their wealthy counterparts experienced visionary treatment. William Tuke, an English Quaker merchant, championed moral treatment in the first decade of the nineteenth century. The theory guiding moral treatment was that exposure to a supportive, benevolent, and moral environment could cure mentally ill people. Believing that mental illness was the result of gluttony and moral indiscretions, moral treatment provided the mentally ill individual with a

sanctuary away from the corrupt influences of their homes and society. Patients received healthy food, tonics, exercise, religion, fresh air, and leisure activities. Unlike their impoverished counterparts, their treatment was respectful. In addition, there was no arbitrary time limit for their care. Moral treatment assumed that most patients would recover spontaneously in their own time (Gerhart, 1990).

As cities developed during the Industrial Revolution, the US began to address mental illness as a social problem. The state's initial response was to build institutions to accommodate people with mental illness; these were initially called asylums, and later mental institutions. During the Jacksonian period, mobility among the population increased dramatically (Conrad, 1992), and mental illness was attributed to changes in the social structure of society. This was important from a policy standpoint, because if social conditions caused mental illness, then society had a responsibility care for the mentally ill. The commonly held belief of the period was that mental illness was curable, and "asylum cure" was the method through which to cure the mentally ill (Conrad, 1992).

Asylum cure involved removing mentally ill people from their homes and communities and placing them in institutions. The institution was supposed to provide the structure and positive values that were absent from society. The goals of asylum treatment were consistent with creating a viable work force for the post-industrial era, so that if they could cure people and return them to society, mentally ill people could rejoin the workforce. Initially asylums were successful in treating mental illness (Conrad, 1992). According to research undertaken by Worcester State Hospital in Massachusetts, recovery rates for mental illness were 58% for all discharged patients (Gerhart, 1990). At the time of that study, the hospital provided moral treatment to all patients. However, data collected 150 years ago is of marginal value, because the

concept of diagnosis has radically changed since that time. There is no way to know how many institutionalized patients suffered with a serious mental illness as opposed to less severe conditions.

In addition to knowing little about the actual diagnosis, we know even less about the after-care in communities post discharge. Nonetheless, mental health caregivers of that time believed that the humane aspects of moral treatment could support the likelihood of unprompted recovery. Consequently, Dorothea Dix advocated for moral therapy in the public hospitals she helped to found. She worked relentlessly to obliterate the almshouses and replace them with treatment facilities or asylums. She spearheaded the development of thirty-two American mental hospitals in addition to others in Canada, Scotland, and Japan (Gerhart, 1990). When first established, state mental hospitals provided individualized and quality care that seemed to result in a high number of patient recoveries. Restraints were rare and only for particularly frantic or violent patients. For a time, state mental hospitals enjoyed the reputation of being environments where people could receive care and a cure for their mental illness (Gerhart, 1990).

Unfortunately, by the early twentieth century caring and healing treatment was abandoned. As the population increased, state hospitals were overwhelmed with more patients than they were able to handle. In addition, they had to take in a large number of patients with poor prognoses such as the elderly, people with organic brain damage, and people in the final stages of syphilis. These outsized and overburdened facilities no longer provided moral therapy. Matters deteriorated through the first half of the twentieth century, when hospitals and asylums neglected and abused people with mental illness. Asylums became custodial care facilities and reverted to practices such as the use of restraints and the administration of drugs for purposes other than treatment (Conrad, 1992). Biological theorists argue that asylums failed because of the

large numbers of psychiatric patients admitted in the 19th century. Psychosocial theorists argue that many people admitted had no psychiatric illness at all, but were social misfits or outcasts in care solely because they were social inconveniences (Shorter, 1997).

The Mental Hygiene Period

The mental hygiene movement was the next era of reform (Grob, 1994; Morisey & Goldman, 1984; Goldman & Morisey, 1985). In 1909, Dr. William H. Welch, Dean of the School of Hygiene and Public Health of Johns Hopkins, founded The National Mental Health Association (NMHA). NMHA advocated for funds to generate new scientific discoveries in asylums, now recognized as mental hospitals. This period saw a shift to creating small hospitals associated with medical schools. Several psychiatric units opened in general hospitals with the goal of moving mental health care into the mainstream of health care. Mental hygienists believed in early treatment and aspired to eradicate serious mental illness. In order to achieve this goal, they advocated for outpatient treatment to identify early signs and symptoms of mental illness. They also promoted follow-up care for patients discharged from institutions. Once again, these treatments were not effective in preventing or curing chronic mental illness. At best, hospitals provided a sanctuary of custodial care. At their worst, hospital staff abused and neglected patients (Grob, 1994). The Great Depression and World War II further aggravated financial problems and overcrowding.

Community Mental Health

By the middle of the 20th century, military mental health professionals developed services that led to renewed optimism about care for people with serious mental illness (Grob, 1994). During this period, community mental health proponents believed that early intervention would improve outcomes for people with mental illness. The National Mental Health Association

(NMHA) and the Group for the Advancement of Psychiatry were instrumental in bringing forward these changes (Grob, 1994).

However, the greatest changes in mental health care occurred during the 1950s with the advent of psychotropic medication. The drug credited with changing the face of psychiatry was chlorpromazine. Discovered by Henri Laborit in 1951, it affected a state of calm. Later, when used in conjunction with other drugs or ECT, it was described that the patients "could play bridge and lead a normal life" (Shorter 1997, p. 249).

At the same time, the public became increasingly aware of the treatment of the mentally ill, and there was growing criticism of mental hospitals. Community treatment became the treatment of choice (Conrad, 1992). Beginning in the 1960s and continuing through the 1970s, community mental health centers were at odds with state mental hospitals. In this environment, the Kennedy and Johnson administrations established a set of counter-institutions in opposition to the state mental hospitals; this marked the beginning of de-institutionalization (Martindale & Martindale, 1985). In 1963, Congress passed and the president signed the Community Mental Health Centers Act (Community Mental Health Centers Construction Act of 1963, Public Law 88–164).

Deinstitutionalization involved discharging patients from mental institutions and supporting them in the community in the least restrictive environment (Gerhart, 1990). De-institutionalization policy had three objectives. The first was to prevent unnecessary admissions and excessive stays in hospitals, and the second was to find consumers appropriate social resources in the community. Finally, de-institutionalization was supposed to improve the conditions of mental hospitals for those who could not survive on the outside. Economic

interests, idealistic interests, legal developments, and the development of anti-psychotic medications led the way to de-institutionalization (Gerhart, 1990).

While state and local legislators saw an opportunity to save money through this initiative, those in private industry saw a way to make money. States had spent large amounts of money on state hospitals and restoring them from disrepair was a daunting prospect. At the same time, not restoring them was not an option. A barrage of newspaper stories, books, and movies such as *Snakepit* (1948) and *One Flew over the Cuckoo's Nest,* (1975) exposed the abuse and neglect that existed in state hospitals. This resulted in the public demanding change. The most expedient solution was to close mental hospitals, particularly back wards. Hospital closing was supposed to bypass expensive renovations and save money. Community mental health care promised to save money and eliminate the abuse people with serious mental illness experienced in state hospitals.

In 1962, Social Security regulations provided for assistance for the seriously mentally ill through Aid to the Permanently and Totally Disabled (APTD). Prior to these regulations, short-term economic assistance for people with mental illness was not enough money for them to survive in the community. The establishment of community mental health centers in 1963 caused some optimism. Legislators who hoped to save money funded the less expensive community mental health centers to provide care and services to the newly discharged patients.

Some people supported these initiatives for idealistic reasons. Goffman (1961) labeled the state institution a breeding ground for mental illness rather than a sanctuary or place of healing. He viewed them as practicing abusive treatment such as padded cells, isolation rooms, straight jackets, water therapies, insulin, and electric shock therapies. In addition, institutional care estranged people from natural supports, such as friends and family, and thus further dehumanized people. Another hazard of in-patient commitment was the stigma people

experienced upon discharge from a hospitalization. Having a history of psychiatric hospitalization could result in not being able to obtain a driver's license, find employment,or marry; overall, it rendered them incapable of living normal lives. Friends, family, and members of the community treated formerly hospitalized mentally ill people as oddities or unusual human beings. Consequently, some people believed mental hospitals should close because of ideological as opposed to economic reasons. They thought these services should close altogether.

Other developments, such as the California Lanterman-Petris-Short Act of 1968, influenced de-institutionalization (Lanteman-Petris-Short Act, 1968). This Act protected people with mental illness from inappropriate involuntary commitment. It established new values and measures for involuntary commitment. Rather than *parens-patrae* considerations, which held that the state had an obligation to care for the helpless, this statute guaranteed previously ignored rights. Similar statutes and judicial decisions followed that protected the rights of the mentally ill.

The discovery of anti-psychotic medications in the 1950s was another formidable factor in the move towards de-institutionalization (Gerhart, 1990). Anti-psychotic medications could stabilize individuals with serious mental illness; it seemed possible to discharge unprecedented numbers of individuals with mental illness into the community who could be symptom-free. The first generation of anti-psychotic medications, while hopeful, caused patients undesirable side effects such as dystonias, akathesia, and pseudo-parkinsonian morbidity. Further, they did little to affect the negative symptoms such as withdrawal and blunted affect, which tended to cause greater discontent to those with serious mental illness. The second generation of antipsychotics, which appeared in the 1980s with the discovery of Clozapine, followed by Respiradol, Zyprexa, Geodone and Abilify, demonstrated a much more tolerable side effect profile and seemed to

address some of the negative symptoms of the illnesses. Although it should be noted, they still result in side effects such as weight gain, high risk of diabetes, metabolic disorders, and high risk of cardio-vascular morbidity (Garver, 2006).

Unfortunately, communities were not ready for the abrupt transition to community-based care or the promise of the success of the new medications that led to speedy releases (Gerhart, 1990). De-institutionalization led to several unforeseen consequences. One was the lack of compassion and abundance of fear most communities held for the mentally ill. In covering the process of the opening of one community residence on Long Island, Winerip (1994) reported that many communities did not welcome mentally ill people. Community members picketed, petitioned against, and vandalized group homes for the mentally ill (Gerhart, 1990). Because of the political power in many wealthy communities, the severely mentally ill found themselves in undesirable and often dangerous locations. There they were at increased risk of criminal victimization; this enhanced feelings of stigma and many preferred to live on the streets.

Another unanticipated consequence of de-institutionalization was the lack of comprehensive community support services to help people remain stable, free of symptoms, and free of re-hospitalization. Case management, an intervention demonstrated to support the success of the mentally ill while in the community, did not have adequate staffing. In addition, staff turnover was high. This left seriously mentally ill individuals suffering the loss of case managers with whom they had developed attachments. Another problem was that community mental health centers established to serve this population preferred to serve higher functioning, more coherent participants, rather than the de-institutionalized seriously mentally ill (Gerhart, 1990).

Among the many unexpected problems that surfaced following deinstitutionalization were a large number of seriously mentally ill young adults who were substance abusers and

homeless. This left them more vulnerable. In addition, unplanned pregnancies were a problem for this segment of the population. They were less likely to engage in social and medical services, and subsequently suffered numerous medical conditions in addition to their psychiatric illnesses.

Finally, the most regressed mentally ill were discharged to privately operated nursing homes that were not subject to adequate regulations. Ironically, the seriously mentally ill who resided there were often permitted less freedom and subjected to more restraints than they would have been in state mental hospitals. In addition, costs were greater than in state hospitals. Hospital closings, coupled with inadequate community resources, led to re-hospitalizations for many people in a depleted hospital system. Hospitals for people with mental illness became even more overcrowded and the quality of care deteriorated. However, similar to World War II and the Korean War veterans, where soldiers with psychiatric problems remained close to their units, many psychiatric patients in the community did well if they remained close to their homes.

In summary, the closing of mental health hospitals and subsequent de-institutionalization led to a mass exodus of seriously mentally ill patients from hospitals into the community. In 1955 there were 558,000 people in-patient in psychiatric hospitals in the US, and by 1989 there were only 130,000 (Clark, 1993). For the most part, the services available to them during this period were inadequate; they were at increased risk of physical harm and stigmatization. The community mental health system was not in a position to serve their needs. Nonetheless, studies have demonstrated that outpatient treatment can boast positive recovery outcomes (Wanchek, et al., 2011).

Contemporary Principles Guiding the Care of the Mentally Ill

The Least Restrictive Environment

A practice principle that emerged during the period of de-institutionalization was that of the least restrictive environment. This concept came about through Lake vs. Cameron, 1966 (Lake **v** Cameron 364 F2d 657, DC Cir 1966), a legal case that balanced restrictiveness of a setting with the basic rights of freedom of a client. This case involved the physical freedom of Mrs. Lake who suffered with a chronic brain condition and was involuntarily committed to St. Elizabeth's Hospital in Washington, DC. She wandered and was often lost. Consequently, keeping her in the locked grounds of the hospital appeared necessary to protect her from herself. However, the court ruled that Mrs. Lake should remain in the least restrictive environment such as a nursing home or a halfway house. Unfortunately, a hearing followed that determined that no outpatient resource had the ability to protect her from her wandering, and she spent the rest of her life on a locked ward. Nonetheless, the case established the principle of "the least restrictive environment" which remains in force today.

Client Self Determination

Another important practice principle that developed during this period was client self-determination; this was a major impetus for involving clients in their own treatment planning. Mary Richmond first articulated this concept in 1922. She recognized that a person could become a guardian to look after the best interests of the client in the event that the client was too ill to protect him or herself. Currently, different states have different guardianship laws. In some states, clients have input in a substituted consent agreement. Further, clients, family members, or guardians can develop a treatment contract which is an agreement following negotiations about treatment goals, how to achieve goals, and the length of time of treatment. This is a way of

garnering shared input, commitment, and responsibility among all parties involved with the patient (Gerhart, 1990). Some feel that some state guardianship laws do not provide enough help to the mentally ill, because they need to be a danger to self or others before they take effect. Opponents fear that anosognosia, or lack or awareness of one's impairment, renders seriously mentally ill people free of treatments that could be greatly bettering their lives (Fuller Torrey, 2006).

Community Support

Policies of de-institutionalization and community mental health care came about without evidence-based treatments or a social welfare system prepared to address the needs of the hundreds of thousands of individuals discharged into their communities with serious mental illness. The Federal Community Mental Health Centers Act (Community Mental Health Centers Construction Act of 1963, Public Law 88–164; Clark, 1993) protected the rights of the mentally ill, recommended obtaining consent for treatment, and began a movement towards community-based treatment. Nonetheless, treatment remained largely coercive. The Act did not make vital supports, such as housing, employment, and community mental health services available to many of the people discharged from hospitals. Although some funding was available for these services, it was inadequate to meet the needs of the large numbers of people returned to the community.

Stigma and bias against the mentally ill remained despite this federal initiative. Instead of returning to a welcoming environment, chronically mentally ill individuals met fear and anger. Many found themselves at the mercy of the criminal justice and welfare systems or became homeless. Others lived in overly structured community residential settings (Grob, 1994). The special needs of this population remained unmet. Although community treatments were not able

to prevent the chronic nature of mental illness, they did appear to reduce morbidity and improve quality of life.

Contemporary Reform

Since 1975, mental health reforms have put more community support in place for people with serious mental illness. Advocates played an important role in these events. They rallied for community-based programs that recognized the bio-psycho-social needs of the seriously mentally ill consumer. Advocates, many of whom were family members or people with mental illness, emphasized helping severely mentally ill people become equal citizens in their communities with access to adequate housing and vocational opportunities. Initially, they focused on social supports; however, as new psychotropic medications and psychosocial treatments demonstrated efficacy, they became incorporated into a new vision of mental health care.

This shift incorporated an increased emphasis on "recovery," a concept consumers of mental health services introduced based on their personal experiences. Through collective personal stories and narratives, consumers began to take an active role in their own treatment and in policymaking. This movement began in the late 1970s and culminated in the development of family organizations such as the National Alliance on Mental Illness (NAMI) and the Federation of Families. These organizations advocated for services for the most impaired. Consumers, who called themselves "survivors," referred less to surviving mental illness and more to the abuses of the mental health system (Davidson, 2006). They founded their own networks and advocacy groups and worked with other advocacy groups such as the Mental Health Association and the Bazelon Center for Mental Health Law (Grob, 1994).

Currently, many factors influence treatment in a complex mental health system. These include the reform movements and their ideologies; financial factors, such as who will pay for what services; advances in care; and emerging treatment technologies. Unfortunately, many people with serious mental illness still have difficulty accessing services and medications that can assist them because of enduring problems such as lack of insurance, discrimination, and stigma.

Stigma is touted as one of the greatest obstacles to community re-integration for individuals with serious mental illness (Buckles et al., 2008; Davidson, 2005; Nelson & Steele, 2007). However, when NIMH declared the period between the 1980s and 1990s the decade of the brain, the phrase represented a paradigm shift that was occurring in psychology at the time. This shift was from faulty-parenting-adverse-childhood experiences model, to a neurobiological one that viewed mental illness as a disease of the brain (Davidson, 2005). This shift, celebrated substantive and long-term reforms in mental health care and redressed the ways in which people in the broader culture view mental illness (Andreasen, 1984). Now, many consider mental illness a no-fault disease. Hopefully, this represents the beginning of de-stigmatization and a more hopeful and compassionate view of mental illness (Davidson, 2005)

Factors such as hope, courage and a sense of belonging are difficult to integrate into a neurobiological model of disorder. Nonetheless, they play a crucial role in the recovery process. Psychological, neurobiological, and Recovery Perspectives all influence stigma and recovery, and it is necessary to ascertain where social workers stand in this debate and whether their practice represents the adoption of an optimistic vision of recovery.

Summary

This chapter reviewed mental health treatment throughout history, focusing on the US, and identifying major shifts in treatment philosophy (Grob, 1994). Early in the nineteenth century, people believed that social changes were responsible for mental illness; they felt that if this was the case, then a cure was possible. During the asylum period, mentally ill persons were removed from the stressful social environment and received moral treatment.

In the early part of the twentieth century, during the mental hygiene movement, again the hope was to cure mentally ill people. During this period, treatment took place in small hospitals affiliated with medical schools. However, financial problems led to overcrowding of these facilities. Ultimately, the best they provided was custodial care. Towards the end of the twentieth century, the community mental health movement arose. This period saw the development of new psychotropic medications, increased public awareness about the plight of the mentally ill, and social criticism of state mental hospitals. This culminated in the Community Mental Health Centers Act of 1963 (Community Mental Health Centers Construction Act of 1963, Public Law 88–164), which called for the funding of community mental health services. However, not enough money supported the social and treatment needs of people with mental illness; limited funding is an enduring problem.

Beginning in 1975, the community support movement recognized the bio-psycho-social needs of the SMI population. Emphasizing equal citizenship, advocates pressed for access to housing and vocational opportunities. A blossoming Recovery Perspective sought to change the definition of recovery from serious mental illness. However, problems with access to new programs remain, and adoption of this new idea of recovery is not universal. The Recovery Perspective remains a vehicle for utilizing the mental health system, and Psychiatric

Rehabilitation is the means to achieve it. It represents a vision for change in the provision of mental health services that incorporates radical shifts from "treatment as usual" in domains such as the role of the practitioner, the role of the consumer, the location of treatment, and the trajectory of treatment.

The next chapter explores the theoretical literature on serious mental illness. A mental health practioner's perspective on the etiology of mental illness has important implications for his or her view of recovery. I will explore two perspectives, biological and psychosocial theories with a discussion of how they converge in the Psychiatric Rehabilitation model.

CHAPTER III: THEORETICAL LITERATURE IN MENTAL HEALTH

Overview

This chapter examines the development of a conceptual therapeutic model for providing recovery-oriented services to consumers with serious mental illness. Over the course of history, numerous theories have competed to explain mental illnesses. Each theoretical framework has a particular perspective and defines mental illness differently. Various psychodynamic, cognitive behavioral, and biological theories are available, some that still identify flaws within the individual or the environment as the source of mental illness (Alloy, Jacobsen & Acocella, 1999). Psychodynamic theories suggest that the individual's unconscious drives are responsible (Freud, 1911, 1926), whereas biological theories suggest that mental illness is the result of brain abnormalities (Alloy et al., 1999; Andreasen, Carpenter, Kane, Lasser, Marder & Weinberger, 2005). Cognitive behavioral theories purport that cognitive distortion of external stimuli are the problem (Alloy et al., 1999; Beck, 1967; Ellis, 1962).

Other theories view shortcomings outside of the individual as the precipitant for mental illness. These include behavioral, family systems, and socio-cultural theories (Alloy et al., 1999). Behavioral theories suggest that people learn dysfunctional behaviors from the environment (Alloy et al., 1999; Ullman & Krasner, 1975). In contrast, family systems theory proposes that problems stem from psychogenic family communication patterns such as double bind messages (Alloy et al., 1999; Bateson, Jackson, Haley, et al., 1956) and high expressed emotion (Alloy et al., 1999; Miklowitz, Goldstein, Neuchferlein, et al., 1995). Socio-cultural theories propose that forces in the external social environment, not those in the person, precipitate problems with mental health (Alloy et al., 1999; Lasch, 1979).

The focus of the proposed dissertation, Psychiatric Rehabilitation and recovery-oriented treatment, are contemporary frameworks for understanding mental illness. They rest on the notion that psychodynamic and biological deficits within the individual, in addition to social cultural forces outside of the patient, are all factors in the development mental illness. As such, practitioners must address all these factors in treatment. In addition, Psychiatric Rehabilitation practice proposes that a person with a serious mental illness needs to learn skills to negotiate their environment and develop environmental supports in addition to treatments that address the internal sources of the illness (Farkas et al., 1989).

In this chapter, I discuss how different theories lead to different definitions of the problem of serious mental illness. I focus on two theoretical models, the psychodynamic, and the biological, and how Psychiatric Rehabilitation integrates those and other models into a comprehensive vision of care.

Psychodynamic Theories and Serious Mental Illness

Freud and the Roots of Psychodynamic Theory

Although Sigmund Freud conducted little if any direct practice with individuals with schizophrenia or other serious mental disorders, his thoughts on the subject have had a profound influence on how psychoanalytic theorists conceptualize these illnesses today. Freud had two theories regarding the pathogenesis of schizophrenic illness (Pao, 1979). The first, described in 1911, was the theory of "decathexis, hypercathexis and recathexis." In his earlier writings, when Freud was principally interested in the libido, he suggested that due to some disappointment with a primary object, the individual with schizophrenia de-cathected libidinous energy from that object and cathected to aggression (Freud, 1911; Arlow & Brenner, 1969; Pao, 1979). Subsequent terror of these aggressive impulses led to a break with reality.

In 1926, Freud revised his theory of psychotic illness and instead proposed "conflict-anxiety-defense" theory. He suggested that an individual with schizophrenic illness experienced a conflict that led to anxiety, which was especially unbearable in schizophrenia (Frosch, 1983; Pao, 1979). To cope with this anxiety, a defense emerges that helps the individual to manage the anxiety and cope with the world. Arieti (1976) speaks of a similar dynamic that he calls "psychotic insight,"where the individual develops a psychotic symptom such as a delusion as a defense against the enormous anxiety of the onset of schizophrenic illness. For example, the mental health consumer who is losing touch with reality develops an "insight" to explain what is happening. As frightening as that explanation might be, it pails in comparison to the loss of reason (Arieti, 1976).

These two theories might appear divergent: one recognizes that an individual may be deficient due to endowment, mal-development, or conflict, and the other recognizes that some individuals have deficiencies (Pao, 1993). The dispute is actually whether people with schizophrenia and other serious mental illnesses are fundamentally different from other people or whether schizophrenic symptoms exist on a continuum with the human experience. One's perspective greatly influences the tendency to stigmatize individuals with serious mental illness. It also influences how different people define "recovery".

Ellis and the Roots of Cognitive Behavioral Theory

Albert Ellis (1994) took a radical view for his time. When most theorists were concerned with unconscious drives and conflicts, Ellis proposed responses to stimuli within the conscious realm precipitated mental illness, not unconscious factors. He developed an innovative treatment, which he called Rational Emotive Behavioral Therapy (REBT). Lacking the complexity of psychoanalytic theory, REBT begins with ABC. "A" stands for "activating" experiences. These

might be a problem with family, work, or any other source of distress. “B” stands for beliefs, in particular illogical, self-harming beliefs that lack supportive evidence that are the actual sources of our malaise, and “C” is for the consequences--the onerous symptoms and negative feelings such as depression, fear, and anger that hail from these beliefs.

Although the activating experiences may actually occur and result in incontrovertible discomfort, it is the illogical beliefs that follow which result in ongoing, crippling problems. Ellis added D and E to correspond to the role of the therapist. The therapist disputes (D), the illogical beliefs, so the client can experience positive therapeutic effects (E) of rational beliefs. Ellis did not believe it was necessary to name the unconscious source of these illogical beliefs. Instead, he believed that thought patterns required interruption. Instead of a deep exploration of unconscious processes, he envisioned a conscious process where a person identifies illogical beliefs (Ellis, 1962).

“Unconditional self-acceptance” is a notion that was important to Ellis. In REBT, no one is bad, no matter how awful the things he or she had done; we should accept ourselves as we are. Other cognitive behavioral theorists such as Linehan (1994) elaborated on these concepts and referred to a similar construct she called “radical self acceptance.” She challenged the client to tolerate the dialectic of practicing radical self-acceptance while accepting that there was a need to make changes.

Beck (1967) is the founder of Cognitive Therapy, also known as Cognitive Behavioral Therapy (CBT). Similar to REBT, this rests on the notion that most psychological distress originates in faulty thinking patterns called thought distortions. For example, with the thought distortion, “mind reading” (Burns, 1999), the individual is convinced that an associate hates them, although there is no evidence to support this. Here the role of the therapist is to help the

client explore and test their beliefs and develop a more realistic view of their circumstances. Some of the thinking errors Beck identified included overgeneralization, minimization of positives, and maximization of negatives. Beck (1967) initially applied his work to depression, but subsequently his ideas have been used to treat anxiety disorders, personality disorders, and even schizophrenia (Boeree, 2006).

Family Systems Theory

Family systems theory proposes that mental health problems stem from psychogenic family communication patterns such as double bind messages (Alloy et al., 1999; Bateson, Jackson, Haley, et al., 1956) and high expressed emotion (Alloy et al., 1999; Miklowitz, Goldstein, Neuchferlein, et al., 1995). Expressed emotion (EE) in those who care for individuals with schizophrenia is the inclination to be critical, antagonistic, and unsupportive of consumers. Double bind messages were once believed to cause severe mental illness, because they confused the identified patient with mutually exclusive directives each with dire consequences for lack of compliance. The practice of blaming families of people with serious mental illness had the effect of alienating clients from their families and increasing stigma towards clients and families; one was the perpetrator and the other was a victim who elicited negative behaviors from family members. This produced a "no win" situation that alienated many families who may have been the sole natural supports for the mentally ill person.

Sullivan and the Origins of Psychiatric Rehabilitation

Sullivan was a follower of Freud. His approach to the problem of schizophrenia was a precursor of the Psychiatric Rehabilitation movement. While Freud felt people with schizophrenia were fundamentally different, Sullivan saw schizophrenia as a part of the continuum of human experience. He believed that everyone has experiences that appear on the

precipice of a breakdown in adolescence, and most are never aware of the omnipresent dangers. People feel "different" in a "shameful" way (Perry, 1962). Some come closer to the edge of florid mental illness than others do. Sullivan believed that people who have had these on-the-precipice experiences with a good prognosis were best suited to work with individuals with schizophrenia.

Sullivan is renowned for his work at Sheppard-Pratt hospital in Maryland. It had a single unit ward for men with schizophrenia. He had strong beliefs about what should constitute the treatment environment. Wards were homogeneous, composed of people of the same gender and general age; he did not invite nurses to participate on the team. This was because he believed that the hierarchical values of our culture contributed to the genesis of schizophrenia and therefore, should not be part of the treatment environment. He handpicked his attendants and made them part of the treatment team in a genuine way; he involved them in rounds and debriefed with them after shifts (Perry, 1962). Sullivan strongly believed in the potential for recovery from a problem that affected so many young people. He also felt the focus of treatment in schizophrenia should be at an interpersonal level, and that people with schizophrenia, in spite of outward problems, had a basic understanding of interpersonal relationships because they belonged to humanity (Perry, 1962).

Sullivan discussed how the notion of recovery swung between poles of complete pessimism stemming from Kraepelin and his followers, to modest optimism. He believed there was a hereditary pre-disposition to schizophrenia and felt that it was not schizophrenic delusions and behavior that forecasted individual prognosis. Instead, he wrote "the dynamics of the several regressions which seemed to be of most importance in predicting recovery, chronicity, or a dementia course" (Sullivan, 1962, p. 13). He emphasized that schizophrenia was a process and

that the level of regression in this disorder was far more severe than that of any other mental illness (Sullivan, 1962).

Without ever using the word, "hope," Sullivan conveyed the importance of this notion:

> If the conservative reorganization of complexes and sentiments which appears to underlie a goodly share of the early schizophrenic phenomenology, leads the patient to the for conscious belief that he can circumvent or rise above environmental handicaps, and this belief is the presenting feature of a comprehensive mental integration, his recovery proceeds. If no such reconstruction is accomplished, the patient does not recover (Sullivan, 1962, p. 15).

For patients with a good prognosis, the environment to which they returned was pivotal to the success of the recovery. This is consistent with Psychiatric Rehabilitation, which emphasizes the necessity of buttressing environmental supports for this population. With regard to relapse, Sullivan challenged the idea that this would be more onerous than the first psychosis due to feelings of discouragement. Instead, he thought that some people fared better after relapse because they learned something from their first experience (Sullivan, 1962).

Sullivan's approach foreshadowed the recovery movement and evidence-based practice in many ways. He declared that those who experienced treatment that was unstudied and provided uninformed interventions did not do as well as those who benefited from well-researched interventions. Here, Sullivan presaged the development of evidence-based practices. He may have been the first theorist to propose that people with schizophrenia did not have to be regarded as hopeless and to believe that people's attitudes towards the patient determined the patient's own sense of worth. He was also aware that people with schizophrenia were acutely aware of the attitude of the practitioner regarding their own life situation (Sullivan, 1962).

Sullivan's approach to schizophrenia held the roots of Psychiatric Rehabilitation. Emphasis on integrating bio-psycho-social elements of treatment, buttressing environmental supports, and examining the role of the mental health practitioner foreshadowed its innovations.

The Psychiatric Rehabilitation Model and Recovery: A Bio-Psycho-Social Phenomenon

The Psychiatric Rehabilitation model was a response to the problem of how to help individuals with severe psychiatric disorders achieve a satisfying life. Responding effectively to this dilemma became increasingly important over the past two decades (Farkas, Anthony & Cohen, 1989). Public policy that transferred people from long term, in-patient care to the community was an attempt to help psychiatric patients achieve satisfaction in life. However, large numbers of people left institutional care for communities that were not equipped to handle them. Although one response to this situation was re-institutionalization (Farkas, et al., 1989), some found that regressive and barbaric. The argument was about where treatment should occur rather than what treatments would be effective. Farkas and colleagues (1989) recognized the profound nature of this debate, which was at the heart of society's inclination to put stigmatized individuals out of sight. Nevertheless, the dilemma of where to treat people with serious mental illness did not address the question of how to help them achieve life satisfaction.

Psychiatric Rehabilitation grew out of the tension between the poor quality of community-based treatment and the desire to help people with severe mental illness live productively in the community. It rests on a philosophy of help that increases success and satisfaction in the environment of choice for the person with mental illness. It also promotes employing the least amount of professional intervention in the least restrictive setting. Psychiatric Rehabilitation is composed of two basic intervention strategies: first, the development of consumer skills, and second, the butressing of environmental resources. Helping a person with a psychiatric disability make a change in their current skill level and changing the environment would result in a person being able to perform the activities necessary to succeed in roles of their choosing (Farkas et al., 1989).

After psychiatric hospitals closed in the 1970s, day treatment programs, partial hospitalization programs, and day hospitals emerged as the treatments of choice for many severely mentally ill individuals. Hospital treatment is still available for those who are a danger to themselves or others or those who cannot care for themselves in the community, but most people with serious mental illness who live in the community participate in these programs (Reger, Wong-McDonald, & Lieberman, 2003).

Reger and colleagues (2003) reported that the first cohort of outpatient treatment facilities was not very different from hospital programs. Both relied on supportive group therapy, social services, medication management, and community meetings. The theoretical framework that guided these programs was usually a psychodynamic model that supported expression of feelings, socialization, and the development of insight (Reger et al., 2003).

In the 1980s, William Anthony initiated Psychiatric Rehabilitation as a new model for providing treatment services for the mentally ill. Psychiatric Rehabilitation programs focus on goal setting for community re-integration, functional assessments, skills training, vocational rehabilitation, and family psycho-education (Reger et al., 2003).

Psychiatric Rehabilitation is inextricably linked with the consumer Recovery Perspective. Both focus on skills building and changing the consumer's environment. The Recovery Perspective is a paradigm shift that transforms the conceptual definition of recovery. Recovery from mental illness under this definition integrates key concepts of living: maintaining a sense of hope and optimism, taking personal responsibility for recovery, and getting on with life (Noordsy et al., 2002).

In the last two decades, the Recovery Perspective has generated a remarkable infusion of hope, because it recognizes the potential of those diagnosed with serious mental illness. In large

part, this is due to a growing consumer empowerment movement in the US, the UK, and other countries. People with mental illness and their families have formed influential organizations that have become increasingly visible and powerful (Turner-Crowson & Wallcraft, 2002). This is evident in linguistic changes across the nation from "patient" to "client" to "consumer," the proliferation of research on evidence-based practices; and the shaping of policy, research, and treatment initiatives.

In the US, the blossoming of a strong recovery perspective has led to a vision of change, reorienting both services and research towards Psychiatric Rehabilitation in practice (Turner-Crowson & Wallcraft, 2002). During the 1990s, various stakeholders debated the implications of adopting a recovery model. Nevertheless, the Recovery Perspective was so strong that in 1999, the Surgeon General urged in his report that all mental health agencies adopt a recovery orientation (Turner- Crowson & Wallcraft, 2002).

The perspective embraces recovery as a process. People with serious mental illness were some of the first people to write about the recovery process; they viewed themselves as "in recovery." Their articles demonstrated how people, who from a prognostic standpoint were once thought lost to the system, were living satisfying and contributing lives in spite of retaining some remnants of the illness. Further, they spoke about the power of the self-help and consumer movements; many people were taking on positions of leadership and modeling their recovery for others (Turner- Crowson & Wallcraft, 2002).

These moving and compelling articles inspired the research and training center at Boston University, which collaborated for some time with consumer-survivor leaders to develop the concept of recovery. By the early 1990s, the center's director, William Anthony, began speaking

to large audiences about the shift from "treating patients" to "facilitating recovery" (Anthony, 1993; Turner-Crowson & Wallcraft, 2002).

Nonetheless, the Recovery Perspective remains controversial. It has attracted the attention of many mental health activists who seek to find "strategies for living" (Turner-Crowson & Wallcraft, 2002). Others may find a perspective that radically challenges the medical model of a lifelong illness, disability, and dependence on services threatening. Inherent in a discussion of recovery is a need to move away from the language of psychopathology. As stated earlier, the concept of psychopathology largely cancels out the concept of hope (Turner-Crowson &Wallcraft, 2002).

In the Recovery Perspective, the practitioner is no longer omniscient and all-knowing (Davidson, 2006). Similarly, the role of the consumer changes in recovery-oriented mental health treatment. People with serious mental illness are encouraged to become active participants in the process. A passive patient acted upon by the mental health system is not "in recovery." Instead, consumers should build bridges to the larger community rather than remaining in a closed community consisting only of mental health providers and other mental health consumers. Previously, a paternalistic system created a sense of "learned helplessness," where consumers felt powerless under the influence of a mental health system that was supposed to be acting on their behalf.

People who promoted the Recovery Perspective rejected this approach, because it encouraged passivity and dependence on mental health providers throughout their adult lives. It is common to encounter individuals who report attending day treatment programs for up to fifty years. Deegan (1996) describes consumers who withdraw and refuse to speak or participate in any meaningful way in their own treatment. Previously, people with mental illness were

supposed to be consumers of mental health treatment for life. Currently, many recognize that people do recover and move on to find meaning and purpose in their lives. Recovery-oriented treatment provides humane, consumer-centered interventions that support individual choice in treatment, education, and finding meaning and purpose in life.

Psychiatric Rehabilitation is the professional practice, and recovery the complementary orientation that drives this approach. Psychiatric Rehabilitation provides a mechanism for operationalizing the values of the Recovery Perspective, which asserts that all consumers are able to benefit by recovery-oriented treatment.

When Kraepelin proclaimed that serious mental illnesses such as schizophrenia were incurable, he issued a challenge for those who followed to try to prove him wrong (Torgalsboen & Rund, 2002). Since then, both biologically and psycho-dynamically oriented mental health professionals have suggested that Kraepelin's grim point of view was not accurate (Bleuler, 1950; Arieti, 1976). Nonetheless, practitioners see recovery from serious mental illness such as schizophrenia in vastly different ways.

Summary

The Recovery Perspective and Psychiatric Rehabilitation have joined biological and psychosocial perspectives on mental illness. They promote the belief that within every individual lays the capacity for recovery, and there is consensus among academicians and researchers that this is the new direction for practice (Anthony, 1993; Davidson, 2005). However, it remains unclear to what extent front line mental health workers, particularly social workers, adhere to this new direction.

The environment of mental health treatment has undergone numerous transformations. In the face of these changes, social work attitudes and practices remain unclear. Although in states

such as New York, mental health authorities expect social workers to practice based on a recovery or psychiatric rehabilitation model, it is unclear whether they do. Currently, we do not know very much about social worker's beliefs, attitudes, and practices with regard to the Recovery Perspective. It is also possible that organizational climate has an influence on social workers' beliefs, attitudes, and practices. In other words, social workers working for agencies that adopt a recovery-oriented perspective may be more likely to embrace this view, while agencies that are resistant to the Recovery Perspective might produce social workers who also resist this view. The chapter that follows examines organizational change and role theory.

CHAPTER IV: THEORIES OF ORGANIZATIONAL CHANGE

Introduction

The problem addressed in this dissertation was the ability of social work mental health providers, both within organizations and in individual practice, to adopt a Recovery Perspective and practice according to principles of Psychiatric Rehabilitation. Just because government entities fund mental health services or reimburse for care that promotes these perspectives providers who practiced in hierarchical systems of care may not necessarily hold views consistent with a new model. This section explores theories of organizational change and role theories that might enrich understanding of these factors as social workers and the organizations where they work have attempted to incorporate the perspectives of people with mental illness.

Flamholz and Randle (2008) discuss the inevitability of change because everything in the human environment is dynamic and subject to change: people, forests, empires, climatic conditions, and organizations. From their point of view, the ability for successful adaptation in both the natural and social worlds requires people to adjust to the changes that occur. Their focus is on organizational success, and they believe that long-term success depends on the ability of an agency to adapt to ever changing situations. They identify three elements that must be in place in order for organizations to achieve this adaptation. These include identifying the types of change needed; understanding phases of the change process; and identifying ways to measure the outcome of change. Change may be incremental, extensive, or transformational. External or internal factors can bring about change (Flamholz & Randle, 2008). In the case of recent reforms in the treatment of people with mental illness, external forces, such as community-based care or funding treatment preferences for evidence-based practices are powerful external drivers for

agency change. Similarly, internal factors, such as the preferences of consumers who populate mental health treatment agencies, are equally powerful.

To change, alter, modify, vary, transform, revolutionize, adjust, or amend are all different words that suggest making something different in a particular way. It may vary from small, incremental change to a complete metamorphosis from one way of being to another. In considering the shift in mental health care towards recovery-oriented treatment, some believe recovery-oriented practice has been in force for a long time. Other stakeholders view the Recovery Perspective as a seismic shift in the approach to mental health treatment (Davidson, 2005).

Lewin (1947) proposed stages in the change process for social agencies (Flamholz & Randle, 2008; Lewin, 1947; Spector, 2007). The first stage is a period of "unfreezing" where unmet agency needs surface and the need for change is identified. Lewin did not believe that "lecturing" organizational players would result in change, but that collaborative processes should surface these agency needs (Lewin, 1947; Spector, 2007). The second phase, "moving," is where activities to support the change, such as communication, re-enforcement, and rewarding techniques, occur. The final phase is "re-freezing," where the organization starts to plan for the inevitability of a new round of changes.

People interested in implementing organizational change often meet tremendous resistance on the part of administration, staff, and consumers alike. Even when programs are not working effectively, people are more comfortable with the known rather than the unknown. Leaders in social agencies who want to implement changes in the way their workers practice must find strategies to address resistance and assist practitioners to adopt changes. There are certain factors that influence resistance, which when explored can help leaders help organization

members to make changes. These include agency values, agency success or failure, and the notion of "groupthink."

Agency values and norms develop over many years; they influence the way people act, and can be difficult to change. People often speak about healthy or unhealthy agency cultures. These cultures are the result of values, ways of being, and behaviors that all players accept or at least tolerate. For example, is it safe for members of the agency to confront one another, including authority? How much does an agency support shared governance and mutual constructive confrontation? Factors such as these can effect whether people are able to try out new ideas and support new practices (Bloom, 1997).

Another factor that can influence whether people are open to change is agency success or failure. When things are going well or appear to be going well, people are less likely to want to make changes. Similarly, the level of investment in the old way of doing things affects people's attitudes toward change. Even when circumstances are not going well for an organization, there can be secondary gains for staff members that render them reluctant to make changes. For example, when social workers practice within the medical model, certain staff members enjoy a degree of elevated status; they are the experts on mental health. Giving this up may have meaning for staff members already insecure about their positions or their roles as healers. Further, in an organizational culture that promotes fear of failure, there is an added disincentive to take risks and adapt to new situations (Flamholz & Randle, 2008).

Another factor that can influence whether a staff is open to change is what Janis (1972) labeled "groupthink." Some agencies develop an "us versus them" culture. This is an environment in which staff is very critical of upper management and likewise, management is very critical of staff. One outcome of this is that people feel an alliance to their group and a

resistance to cooperating with anything initiated by the other. This develops a mindset that is not open to change. There are individual factors that can fuel this situation, including insecurity, apathy, and a sense of personal vulnerability. Addressing the presence of any of these three factors is necessary in effecting a successful organizational change.

Change can either be proactive or reactive (Bloom, 1997; Flamholz & Randle, 2008). An organization initiates proactive change because of anticipated environmental or agency situations in the future. In contrast, reactive change is a response to changes in the environment that have already occurred. Social workers surveyed in this study worked in various agencies or as individual practitioners where adopting a Recovery Perspective or Psychiatric Rehabilitation model proactively or reactively may have occurred.

Another organizational theorist, Holbrech (2006), suggests two different theories of organizational change. Theory E is change based on economic value, and Theory O is change based on organizational capability. Theory E is reactive, and Theory O responsive. Theory E includes reflexive reaction to an economic necessity, and Theory O focuses on more long-term outcomes of a change. Theory E suggests that change comes about because of the economic climate of the time. This type of change may leave professionals feeling disempowered and forced to make changes based on financial necessity. Rarely do people who make changes because of economic reasons feel that the changes are in the best interest of consumer treatment. Theory O, on the other hand, suggests there is an organizational push for the change, such as a change in mission, ideology, or values. Here change is more likely to be responsive rather than reactive; thought through in terms of long term implications for treatment; and more likely, although not necessarily, to be embraced by staff. The subjects in this study may have been working during a period of time when agencies were adopting a recovery-oriented paradigm

because of economic necessity driven by funding sources. Others might have been working in settings influenced by stakeholders within their organization who had vision of change. It is possible they had a strong belief in and acceptance of recovery principles. These contrasting circumstances could affect individual social workers' perceptions of the change and the new demands placed on them.

Role Theory

Just as change influences agencies as a whole, change within an organization effects individuals. Role theory helps explain how individuals deal with change in their environment. Moreno (1961) originally developed this concept as an approach to strengthen spontaneity, creativity, and contemporary understanding of role theory still resonates with this original idea. "Role" is as a pattern of human behaviors (Biddle, 1979; Mendenhall, 2007). These patterns of behavior appear in social interactions and as individuals hold various social positions. As people assume new roles, they negotiate previous beliefs and behaviors with the beliefs and behaviors expected when they assume a different role or position (Mendenhall, 2007).

Role theory examines how roles develop and how they affect behavior as people attempt to adapt to roles in different contexts or as they assume new positions. Important concepts associated with this process include social function, context, and expectations. Social function refers to one's role within society and the inherent expectations. The context of a role has to do with the definition, status, and expectations of the person occupying a role. Expectations refer to how a role influences an individual's behavior, both in what they expect of themselves and what others expect of them (Biddle, 1979; Mendenhall, 2007).

Role theory is concerned with the feelings that surface as people assume new roles (Mendenhall, 2007). These include role ambiguity, role conflict, role overload, and role

discontinuity (Davis, 1996; Mendenhall, 2007). Role ambiguity suggests that expectations are unclear or incomplete. Role conflict occurs when a person has problems performing a role because of conflict among various roles and subsequent values inherent in each role the person must assume. Role overload occurs when a person has too many conflicting roles. Finally, role discontinuity is the lack of integration between roles in sequential life stages.

Role discontinuity was particularly relevant for this study because it occurs when individuals transition to new roles that are different from their previous ones in areas such as characteristics, context, and expectations. This discontinuity can have unfortunate consequences including negative feelings, difficulty meeting expectations, or even failure to accept the new role (Mendenhall, 2007). Considering how role discontinuity may play out for social workers who must transition from a role that is intrinsically paternalistic to one that shifts decision making to the person with mental illness was an area of exploration in this research.

Some have addressed this particular problem for mental health workers asked to incorporate a new approach to their practice. Davidson and colleagues (2006) discuss concerns raised by practitioners asked to transition to recovery-oriented practice. These include a belief that recovery is "old wine, new bottle" (Davidson, O'Connell, Tondora, Styron & Kangas, 2006, p. 1). They found that some practitioners believed that they already practiced recovery-oriented treatment even without the training generally assumed vital for adopting this approach. In contrast, some mental health workers believed that practicing recovery-oriented treatment would burden already extensive work responsibilities. Others defined recovery as cure and were upset at the suggestion that severely disabled clientele could be cured, a proposition they viewed as unrealistic. Some mental health workers believed that recovery only occurred for the lucky few. In this instance, the subjects thought it was unethical to offer any hope for recovery (Fuller

Torrey, 2006). Similarly, some workers believed recovery was an irresponsible fad that set people up to fail (Fuller Torrey, 2006). More traditionally trained mental health workers may believe that recovery comes from insight, and if someone does not believe they are sick, they are not in a position to discuss recovery. In summary, if some workers believed that recovery-oriented treatments put workers more at risk, they may fear for their personal safety or liability (Davidson et al., 2006).

Other areas of resistance to embracing a recovery model relate to concerns about external forces that will make change difficult. For example, considerable skepticism abounds regarding whether the necessary resources will be available to mount new and expensive recovery-oriented programs. Even with claims that many of the Psychiatric Rehabilitation models of practice are associated with evidence-based practices, some workers are skeptical that they actually work (Davidson, 2006).

There are many reasons why social workers might find it difficult to move from traditional, paternalistic treatment for mental ill patients to recovery-oriented treatment, all of which have the potential to cause distress and resistance. If practitioners do not fully understand the recovery perspective, it may cause role ambiguity. They may not be able to match their ethical stance about treatment with the values proposed by the Recovery Perspective, leading to role conflict. If social workers have difficulty embracing psychiatric rehabilitation, it may be a response to over-work and thus role overload. Perhaps most significantly, role discontinuity may explain why some mental health professionals reject the recovery model.

Alongside organizational change theory and role theory, there is much to be learned from the effort to transport evidence-based practices (EBP) to mental health agencies. Again, factors facilitating and factors creating obstacles to organizational change are at play. In spite of an

abundance of support for EBP in laboratories, followed by professional organizations supporting this initiative, there has been resistance to implementation in mental helath agencies at large.

Evidence-Based Practices

In recent years, the field of mental health has recommended the use of evidence-based practices (EBP). There has been tremendous support for these initiatives. In 2005, the American Psychological Association promoted the use of EBPs in professional psychology. Similarly, the Institute of Medicine (2001) supported the use of EBPs and made a statement regarding the importance of EBPs across various areas of health care. This has been part of a larger plan to better integrate clinical research findings with practice in mental health services. In 2003, the President's New Freedom Commission on Mental Health asserted that disseminating EBPs in clinical settings should be a national priority. Furthermore, the National Institute for Mental Health (NIMH, 1998) aimed to address the gap between research and practice by funding incentives to implement EBPs in practice settings. Thus professional organizations such as the APA, peer reviewed journals, and esteemed authors have all supported EBPs and began a movement toward greater implementation of these approaches (Nelson & Steele, 2007). Nevertheless, EBPs are underutilized in clinical settings. In spite of the support for EBPs, there are many who are skeptical about their efficacy or raise other questions about their adoption.

Nelson and Steele (2007) examined potential predictors of practitioner EBP use. Among these were factors related to practitioners' training and the support of the clinical setting in which they worked. Aarons (2004) reported that practitioner's level of education and clinical experience related directly to their embrace of EBPs in their work. Attitudes were a third potential predictor of EBP use. In general, attitudes towards manualized treatment programs vary and treatment manuals are a defining characteristic of EBPs.

Nelson and Steele (2007) hypothesized that practitioner training, the culture of the clinical setting, and the practitioner's attitude towards treatment research were significant predictors of EBP utilization. Their study supported these hypotheses. Also influential were practitioner's self identified theoretical orientation and the type of clinical setting. These factors may be significant to understanding practitioners' embrace or lack thereof of a Recovery Perspective. Practitioners and scholars within the mental health field are suspicious of blind adoption of evidence-based practices.

Dissemination and Transportability

The subject of transportability of EBPs has been discussed in articles focused on children's mental health (Leadbeater, 2010; Ogden, Karki, Stegenborg-Teigen, 2010) and psychotherapy research (Dattilio, Edwards & Fishman, 2010; McHugh & Barlow, 2010; & Schoenwald & Hoagwood, 2001). Transportability refers to the movement of an evidence-based practice from the laboratory to usual care settings. There is an inherent fissure between treatment efficacy as tested in controlled settings and treatment efficacy once disseminated to practice facilities. Variables that account for the differences include intervention characteristics, practitioner characteristics, client characteristics, service delivery characteristics, organization characteristics, and service system characteristcs. All of these characteristics relate to transportability of different types of interventions (Schoenwald & Hoagwood, 2001). For example, heterogeneous populations and high caseloads do not impinge on research settings. This means that when an EBP is adopted, it is rarely adopted as it was originally tested. Therefore, if it is adopted, there are important questions about fidelity to the original model and its sustainability within real life settings

Leadbeater (2010) expounds upon the obstacles to dissemination and suggests that there are organizational infrastructures necessary to support the dissemination of evidence-based practices. Many agree that research and practice are disconnected from each other (Dattilio et al., 2010; Schoenwald & Hoag, 2001). Suggestions for overcoming this problem include incorporating a combination of randomized control studies with qualitative examinations of the implementation of treatment programs and systematic case studies (Dattilio et al., 2010). This would have the effect of triangulating the research and seeing not only the generalizable outcomes, but also outcomes in context.

There is much to be learned from the Norwegian research system, which comprehensively links policy, practice, and research. In other words, the Norwegians make a concerted effort to narrow the gap between research, practice, and policy. First, the Norwegian Directorate of Health is responsible for compiling various ordinances, national guidelines, and campaigns. It then advises the government on health policy and legislation. Consequently, they have been instrumental in establishing a number of centers for research, implementation, and education. Many are attached to university research settings, but some attached to organizations. Norway has imported EBPs from the US, and has had to consider the same transportability issues—would these interventions work equally effectively in a different country? They found that with sufficient resources, strong collaborative relationships between developers and implementers, availability, and enthusiasm for EBPs there was considerable success (Ogden et al., 2010). Interestingly, transportation of similar EBPs in Sweden were not as successful. Researchers concluded that there is a necessity of strong economic and administrative support to assist implementation, carry out research, and attend to fidelity (Ogden et al., 2010).

McHugh and Barlow (2010) elaborate on procedures for comprehensive assessment and training in leading dissemination programs. These include a needs and barrier assessment, a training structure, didactic training, competence training, outcomes collected, and consideration regarding sustainability. These procedures, coupled with sufficient resources, strong collaborative relationships between developers and implementers, and an overall campaign to garner support and enthusiasm appear to be necessary preconditions for transportability.

Summary

In summary, an organization's embrace of change, individual practitioners' role flexibility, and individual practitioners' endorsement of research and evidence-based practices suggested factors for examination in this study. The following chapter looks at the empirical literature related to recovery from mental illness.

CHAPTER V: REVIEW OF THE EMPIRICAL LITERATURE: RECOVERY FROM MENTAL ILLNESS

Introduction: A Brief History of Social Work and the Psychiatric Professions

In the US, the mental health system relies heavily on social workers. However, few are aware of social work expertise in interviewing techniques, analytical methods, and healing processes (Alperin, 1977; Kirk, 2005). Mental health consumers sometimes express disappointment or concern when assigned to a social worker rather than a psychiatrist or psychologist for therapeutic treatment. The reasons for this are varied. They may have to do with the historic roots of social work serving the poor, the relationship between social workers and psychiatrists, and the history of the social worker's role in psychiatry.

Social work began in the late nineteenth century when religious communities began promoting the notion of charity. The "friendly visitor," who was the original caseworker, was a volunteer worker who provided people who were poor, unwell, criminal, or similarly disenfranchised with help. They also strove to provide moral insight into behaviors that were purported to lead to a life of adversity (Alperin, 1977). Although friendly visitors had kind and noble intentions, there was no empirical evidence or theoretical frameworks guiding their practice. To this day, the work of friendly visitors lacks recognition.

Nonetheless, beginning in the early twentieth century, social workers found work in many of settings, including medical, psychiatric, school, and correctional facilities. Social workers with the most prominent status were those employed in psychiatric or medical settings. Social workers who worked with physicians integrated the high status of the doctor into their nomenclature by calling themselves "psychiatric" social workers or "medical" social workers. This identification with doctors was an effort to seek status and professional identity. Social

workers began to focus on the symptoms and causes of social problems, and began making social diagnoses. This distinguished social workers from laypersons or the friendly visitors, and advanced the profession's interest in seeking a scientific knowledge base. Professional training programs for social workers began with the New York School of Philanthropy in 1898, followed by of the establishment of numbers of social work programs over the last century (Alperin, 1977; Gerhart, 1990).

In their work with people with mental illness, social workers's responsibilities grew in psychiatric care. At first social workers were assistants to psychiatrists. While a psychiatrist worked with the primary patient, social workers met with the family to collect historical and developmental data. Over time, social workers in mental health became the liaison between the psychiatrist, the family, and the patient. Ultimately, discharge planning became part of the social worker's professional portfolio. Over time, it became clear that the primary patient was not necessarily the only one with pathology, and family members needed mental health treatment, too. In most cases, social workers became the primary therapist for family members, while the psychiatrist worked with the identified patient (Gerhart, 1990).

Initially mental health workers attempted to establish clear boundaries between the responsibilities of the social worker and those of the psychiatrist. Inevitably, this proved impossible; there was greater common ground between social workers and psychiatrists, and eventually social workers began to treat identified patients (Alperin, 1977). With the introduction of psychotropic medications, physicians were the only professional group who could prescribe them. In the context of this dissertation, which explored social worker's adoption of a Recovery Perspective with mentally ill consumers, the question emerges whether social work has extricated itself from a medical model of practice.

This chapter explores the empirical literature on recovery from both the medical and the recovery-oriented perspectives, followed by a definition of "recovery" from a recovery-oriented perspective, examination of the effects of mental health professionals on recovery, and finally, presentation of the literature on practitioners' attitudes towards mental illness. This chapter will conclude with an identification of gaps in the literature.

Medical Model vs. Recovery Oriented Paradigm

Studies imbedded in a medical model define "recovery" as reduction in symptoms, decrease in number of hospitalizations, and attainment of functioning (Andreasen et al., 2003; Bellak, 2006). The concepts of cure, remission, and recovery are often confused. A cure suggests that an ailment is eradicated, no longer in existence, and no longer plaguing the sufferer. Remission suggests that while symptoms have abated, the illness is still present and the individual is forever in peril of a resurgence of symptoms. Consequently, recovery was originally a medical concept equivalent to "cure." However, contemporary proponents of the Recovery Perspective define "recovery" in a much more complex and fluid way without a specific endpoint or eradication of the illness (Loveland et al., 2005).

Since the 1980s, practitioners who have employed a recovery-oriented perspective have found strongly for recovery from serious mental illness. Most of this research has been consumer generated and has not employed a medical definition of recovery (Mead & Copeland, 2000; Smith, 2001; Tooth et al., 2003). The definition of "recovery" put forth in these studies identifies closely with the consumer movement in mental health. Proponents of the Recovery Perspective propose recovery is a process rather than an outcome, that it is non-linear, and that it unfolds in stages. Recovery-oriented proponents' approach to research is primarily inductive and developed from talking to subjects about their experiences and allowing definitions to emerge. These

definitions incude many different facets, such as finding hope, taking responsibility for illness management, and finding purposeful meaning in life (Noordsy, et al., 2002).

In contrast, the definition of "recovery" from a medical perspective provides researchers with clear, measurable outcomes. The consumer-driven definition makes recovery more difficult to measure, although recovery-oriented researchers are working to operationalize the consumer-based definition of recovery (Andreasen et al., 2003, Davidson et al., 2005; Lieberman et al., 2002; Noordsy et al., 2002) to create measurements consistent with this definition. However, these contrasting definitions emerge from the values of treating professionals on one hand or consumers on the other.

Consumers and practitioners who identify with the Psychiatric Rehabilitation treatment model define recovery in a manner similar to the medical perspective. Both consider a return to social and vocational role functioning as a measure of recovery. However, rather than viewing the relationship between the practitioner and the patient in a hierarchical manner, Psychiatric Rehabilitation practitioners situate themselves as partners or recovery guides in the journey toward recovery (Davidson, 2005). Another way they view Psychiatric Rehabilitation is as a bio-psycho-social model that recognizes although positive or negative symptoms may exist, occupational and social functioning are equally important in achieving recovery.

Under the recovery rubric, consumers, survivors, or ex-patients have a different definition of "recovery" that suggests serious mental illness is a social construct and a response to overwhelming stressors such as poverty, substandard housing, interpersonal, and environmental abuse, and stigma. At their most extreme, subscribers to this perspective believe that any intervention from the medical profession is unwelcome, including medication or long-term care. This perspective grew out of the consumer-survivor-ex-patient movement of the 1970s. It does

not accept a disease model. Instead, it recognizes that individuals play an active role in their recovery process. Recovery is non-linear and its elements include hope, meaning, life-purpose, and relapse (Loveland, et al. 2005). People committed to this model believe that recovery is a process of continuous growth, increasing control over one's life, and a sense of self, definition, or re-definition. It is a highly individualized process without an externally imposed endpoint (Loveland et al., 2005).

Each of the three approaches to psychiatric outcomes, the medical, Psychiatric Rehabilitation and Recovery Perspectives, have led to different methodological research approaches that are consistent with how they define recovery. Research from a medical perspective is more likely to use a positivist or post-positivist approach. As they develop evidence-based practice interventions, they employ systematic reviews to determine treatment effectiveness. Measurable outcomes and valid and reliable instruments to measure outcomes are an important part of their research. These studies are increasingly important for all practitioners who work with people with serious mental illness, because they provide the basis for evidence based practices.

On the other hand, researchers with a recovery orientation are more likely, although not exclusively, to utilize constructivist research methods in an attempt to elevate the process and experience of recovery. They often use qualitative methods that employ personal narratives to understand the nature and process of recovery and how it unfolds. Both positivist and constructivist paradigms are important in learning more about the phenomenon of recovery.

Research on Schizophrenia and Recovery Rates

There was a wealth of research on rates of recovery from mental illness throughout the 20th century. It is beyond the scope of this study to review the large number of studies on serious

mental illness and recovery rates. However, two systematic reviews examine studies of recovery rates, and I examine them here. These include the work of Warner (2004), and Calabrese, and Corrigan (2005).

Systematic Reviews of Studies of Recovery Rates

In 2004, Warner found 114 outcome studies that defined "complete recovery" consistent with a medical perspective and one similar to a Psychiatric Rehabilitation perspective. This definition was either the complete cessation of psychotic symptoms and return to a previous level of functioning or "social recovery." Social recovery was residential and social independence and little social disruption, in addition to sufficient employment to provide for one's own basic needs. These studies examined recovery and hospitalization rates for people diagnosed with schizophrenia. The earlier studies he identified (Bleuler, 1950; Bond, 1921; Evensen, 1904; Freyhan, 1955; Kraepelin, 1919; Lemke, 1935; Mayer-Gross, 1932; Muller, 1951; Murdoch, 1933, Otto-Martiensen, 1921; Rennie, 1939; Rosanoff, 1914; Stearns, 1912; & Strecker & Willey, 1927), found for between zero and 30% "complete recovery" and between five and 60% for "social recovery," in which 66% of the study participants were hospitalized. These studies painted a bleak picture of the possibility of recovery from schizophrenia.

Toward the latter part of the twentieth century, long-term follow up studies on recovery from schizophrenia yielded results that are more positive. Warner (2004) found that recovery rates for schizophrenia were not significantly better at the end of the twentieth century than they were at the beginning of the century; "complete recovery rates" were at 20%, while "social recovery rates" were between 35 and 45%. Although Warner (2004) concluded that a clear picture of outcome in schizophrenia had not emerged, Calabrese and Corrigan (2005) found more optimistic outcomes. In contrast, Calabrese and Corrigan (2005) reviewed ten recent

studies with more promising findings. The first of these was conducted by Manfred Bleuler, son of Eugen Bleuler, who questioned his father's belief in the hopelessness of a diagnosis of schizophrenia. This group of studies (Bleuler, 1978; Ciompi, 1980; DeSisto, Harding, McCormick, Ashikaga, & Brooks, 1995; Harding, Brooks, Ashikaga, Strauss, & Briere, 1987; Harrison et al., 2001Huber, Gross, Shutler & Linz, 1980; Marneros, Deister, Rohde, Steinmeyer, & Junemann, 1989; McGlashan, 1984a, 1984b; Ogawa et al., 1987; Tsuang & Winokur, 1975) called into question pessimistic views on recovery.

On average, these studies found 55% of subjects improved or recovered at the end of follow up that ranged from 15 to 37 years. Some individual studies that measured recovery among schizophrenic patients are notable. A study conducted in Japan (Ogawa et al., 1987) found the highest percentage of recovery, 77% at 22 to 27 years follow up, while the Chestnut Lodge Study conducted in Maryland (Glashan et al., 1984a, 1984b) found the lowest, only 36% improved or recovered at 15 years follow up. The results of these studies vary greatly. However, all found for some degree of recovery.

The most intriguing of all studies reviewed was the Vermont Longitudinal Study (Harding, et al., 1987) where researchers followed 269 individuals diagnosed with chronic mental illness for an average of 32 years. These were individuals with a diagnosis of schizophrenia hospitalized in the back wards of Vermont State hospital for at least six years. This study was different from the others because patients received treatment with an innovative rehabilitation program and were discharged into their communities with supports in place.

This pioneering rehabilitation program began in 1955 when a multi-disciplinary clinical team sponsored by the Vermont State Hospital and the vocational rehabilitation division of the Vermont State Department of Education developed and implemented a program of wide-ranging

rehabilitation services and community placement and support for consumers who had been admitted to the backwards of the hospital. Between January 1955 and December 1960, 269 consumers considered most seriously mentally ill received referrals to this program (Harding et al., 1987). The staff received retraining in this new method, and the program developed in collaboration with consumers. Treatment included psychotropic treatment, open ward care in a comfortable environment, group therapy, graded privileges, activity, vocational counseling, and self-help groups (Harding et al., 1987).

The community treatment component of the program involved the same team of practitioners going into the community and ensuring that appropriate treatment, housing, and occupational opportunities were available as connections to natural support systems. At that time, a period of custodial care and before the development of community mental health centers and later de-institutionalization, this comprehensive program was radical and innovative. At follow up, one-half to two thirds of all participants improved or fully recovered (Harding et al., 1987).

DeSisto and colleagues (1995) conducted a follow up study to determine the efficacy of the rehabilitation model utilized in the Vermont study. They used a group matching design and compared the outcomes of 269 individuals in Maine with the 269 individuals in the Vermont Longitudinal Study. The research subjects of the Maine-Vermont Comparison Study received treatment as usual rather than the innovative rehabilitation program. Although roughly half of the Maine-Vermont Comparison Study subjects demonstrated positive functioning on the Global Assessment Scale, they did not do as well as the Vermont Longitudinal Study participants. The study authors speculated that the Vermont participants, who received skills building and environmental supports, were better able to negotiate life on the outside of the hospital.

Here, two forces converged to bring the notion of recovery to the fore. The first were the long-term outcome studies just discussed which demonstrated that the course of the illness was much more variable both across and within individuals, and that many people could have positive outcomes often without maintenance medications (Bellak, 2006; De Sisto et al., 1995; Harding et al., 1987). The second was the consumer movement which grew out of the collective personal stories and narratives of individuals who themselves had recovered from serious mental illness (Bellak, 2006; Davidson, 2005). This new empirical data combined with the strength of consumer voices led to political change that affected service delivery and public opinion about serious mental illness. This concept of recovery from serious mental illness, which Bellak (2006) suggests would have been an oxymoron only years ago, became a major focus of interest among researchers, practitioners, consumers, their families, and health professionals at the local, state, and national level. Recovery may now be possible or even typical (Bellak, 2006).

Research and the Recovery Perspective

Consumer Generated Literature

Traditional approaches for people with mental illness emphasize a hierarchical relationship between practitioner and consumer in which the practitioner is the person with the knowledge (Nelson, Lord, & Ockoka, 2001). Further, these approaches to mental health have emphasized diagnosis of deficits, symptom reduction, and skill building (Nelson et al., 2001). In this traditional approach, symptom reduction emphasizes positive symptoms, such as hallucinations and delusions, as opposed to negative symptoms, such as flat affect or social withdrawal.This limitation expresses the concerns of the medical provider more than that of the consumer (Nelson et al., 2001). In addition, people with serious mental illness still suffer from stigma and subjugation that poses a barrier to accessing beneficial treatment (Lord & Dufort,

1996; Vogt, 2011). Consumers needed new approaches to address issues such as their lack of power and control, stigma, poverty, unemployment, and substandard housing. The 1990s evidenced a shift in focus toward a Recovery Perspective in the field of mental health (Davidson, 2008; Kidd, George, O'Connell, Sylvestre, Kirkpatrick, Browne, Odueyungbo, 2011; Nelson et al., 2001; Turner-Crowson & Wallcraft, 2002) accompanied by constructivist research studies that highlighted the voices of those who suffered with mental illness. This became the research method of choice for consumer-oriented researchers. It paralleled their desire to help people with serious mental illness live full and productive lives in the community. It was through this approach to inquiry that a new definition of recovery emerged. What follows is a discussion of some of the key facets of this new definition.

A Definition of Recovery from Consumer-Generated Literature

Consumer -generated literature included personal stories and narratives written by consumer-survivors (Coleman, 2003; Coudin-Schiff, 2004; Deegan, 1988; Legere, 2007; Mead & Copeland, 2000; Salsman, 2003; Smith, 2000; Sundstrom, 2004; and Weiner, 2003). Some sought to give voice to the lived experience of consumers of mental health services. Others undertook qualitative studies (Andreasen et al., 2003; Davidson, 2005; Forchuk, Jewell, Tweedell, & Steinagel 2003; Jacobson & Greenley, 2001; Lieberman, 2002 ; Mead & Copeland, 2000; Nelson et al., 2001; Noordsy et al., 2002; Resnick, Fontana, Lehman & Rosenheck, 2005; Ridgway, 2001; Smith 2000; Tooth et al., 2003; Whitehorn, Brown, Richard, Rui & Kopala, 2002). In both cases, these works supported an emerging definition of recovery. They elucidated the power of hope and other factors associated with recovery; enlightened us that recovery was a process and not an arbitrarily defined endpoint; and explored the changing demands on the relationship with the professional helper in this new paradigm.

Themes that emerged in the literature included finding hope (Andreasen et al., 2003; Davidson, 2005; Deegan, 1988; Noordsy et al., 2002, Resnick et al., 2005, Ridgeway, 2001; & Tooth et al., 2003;); resuming control and responsibility (Andreasen et al., 2003; Davidson, 2005; Ridgeway, 2001; Tooth et al., 2003 Whitehorn et al., 2002); the redefinition of self (Andreasen et al., 2003; Coudin-Schiff, 2004; Davidson, 2005; & Ridgeway, 2001); acceptance of illness (Davidson, 2005; Ridgeway, 2001); overcoming stigma (Davidson, 2005); empowerment, (Davidson, 2005; Jacobsen & Greenly, 2001; Resnick et al., 2005); managing symptoms (Davidson, 2005; Noordsy et al., 2002; Whitehorn, 2002); having a social support network (Davidson, 2005; Jacobsen & Greenley, 2001; Ridgeway, 2001; Tooth, 2003); being involved in meaningful activities (Andreasen et al., 2003; Davidson, 2005; Noordsy et al., 2002; Ridgeway, 2001; Whitehorn et al., 2002); and developing a spiritual life (Davidson, 2005; Lieberman et al., 2002).

Finding hope is the element of recovery most emphasized in the literature. Ridgway (2001) analyzed the content of four seminal personal stories and narratives that addressed the questions: what do first person accounts reveal about the process of recovery from long-term psychiatric disability and what common themes emerge from systematic analysis of such personal stories and narratives? A common assertion by the subjects was mental health workers told them they would never get better (Ridgeway, 2001). Ridgeway's study and others reported the desire of people with severe mental illness to rekindle hope. Hope appears as a primary factor throughout the recovery literature (Andreasen et al., 2003; Davidson et al., 2005; Noordsey et al., 2002; Resnick et al., 2005). "Hope," or "finding hope," or "hope and optimism" speak of the same phenomenon. In this context, "hope" is having a sense of optimism and belief in a better future.

Along these lines, Tooth and colleagues (2003) conducted qualitative interviews with people in recovery who were determined to get better. They took a very strong consumer-oriented stance in their research. They interviewed sixty individuals who met the criteria for schizophrenia. Further eligibility criteria included a self-report of being in recovery (Tooth et al., 2003). Their rationale was that in order to understand recovery from a consumer perspective, it did not make sense to begin by imposing their own definition of recovery. This was an important and empowering position to take and was consistent with inductive inquiry. Their findings surfaced consumer-centered and anti-medical system sentiments. A determination to get better relied less on a mental health practitioner to instill hope. This highlights what their study found; people in recovery often valued their own determination and not the expertise or care of professionals (Tooth et al., 2003). Finding hope and determination remain key facets of the recovery model definition of recovery.

Another important factor or process in the definition of recovery is re-defining the self. Masterson (2000) claimed that people are capable of performing many tasks. A healthy self exhibits spontaneity; lively affect; self activation; self soothing, and self support; capacity for commitment, creativity; and the capacity for regulating affect and self esteem. A healthy person is capable maintaining stability of self. Kernberg (1984) also addressed the notion of maintaining a stable set of values when he proposed that a distinguishing marker between neurotic personality organization, borderline personality organization, and psychotic personality organization was the ability to maintain a stable sense of self.

These aspects also appear in the work of Coudin-Schiff (2004), a consumer and mental health professional, who wrote about the assault to the sense of self in psychotic illness. In speaking of the needs of people with mental illness, she claimed that the illness interrupts one's

life path. Illness itself becomes an identity, but a negative one. People often say, "I do not feel like myself," when they feel sick. Societal and self-stigma occur when being ill becomes a part of one's identity, and therefore, there is a need to re-build a self-identity. Coudin-Schiff (2004) and Deegan (1996) suggest that one's perspective on mental illness needs to shift from an identity of being a mental illness ("I'm a schizophrenic,") to seeing the whole person of which mental illness is just one part. However, this is particularly difficult when others see the person as the illness and not a whole person. Sundstrom's (2004) first person account as a family member of a person with schizophrenia states, "Sometimes it is impossible to tell where the disease ends and my sister begins. When a disease affects the mind, the person and the disease become almost one" (p. 192).

Accepting the illness is another feature of this definition of recovery. This process involves recognition of symptoms and the impact they have on functioning. It does not impose limits on what one can achieve in life; accepting the illness requires recognizing what skills and environmental buttresses will help one achieve life goals. Davidson (2005) conducted a qualitative study to understand the consumer experience of psychosis and cautioned that accepting the illness does not mean accepting the role of mental patient. Instead, it means accepting mental illness as one of life's challenges. Similarly, Deegan (1988) stated, "that in accepting what we cannot do or be, we begin to discover what we can be and what we can do" (p. 15). Noordsy and colleagues (2002) agree the irony is that once one accepts that one has an illness, the illness loses some of its power over the individual.

Overcoming stigma is another process in the definition of recovery, and a number of studies addressed stigma as a major barrier to recovery (Davidson, 2005; Smith, 2000; Tooth et al., 2003; Vogt, 2011). Because people are social creatures who do not live in isolation,

individuals with severe mental illness often internalize social stigma. They may take on the sick role or the role of mental patient (Davidson, 2005; Goffman, 1961). In the phrase, "consumer-survivor-ex-patient," consumers are referring to surviving the mental health system rather than the illness itself. People with mental illness report their disappointment with mental health professionals who make suggestions that make them feel hopeless (Salsman, 2003). Other consumers may play a more important role in supporting recovery than professionals Davidson, 2008; & Topor, Borg, Di Girolamo, 2011). Salsman (2003) found the most helpful intervention she ever received was from another consumer who stated, "Yeah that happened to me too." Stigma occurs when others view a person as different, worthless, and incomprehensible; consumers seek to be valued as equal and contributing members of society.

Empowerment suggests that a person can assume control over their own recovery process, and it is a central feature of the self-help movement. For over a century, people diagnosed with serious mental illness could not participate in decision making regarding their own treatment. Coleman (2003) in her personal story speaks of Paseo Village, a residence in Albequerque, New Mexico, where "independent living means being allowed to make the same choices and the same mistakes other people are allowed to make … we were allowed to come and go as we pleased, in our own homes, and do whatever we wanted with our own time." (p. 399). Coleman (2003) describes how natural support groups emerged within the community.

In another study researchers interviewed consumers, line staff, administrators, peer counselors, and other stakeholders retrospectively following an organizational shift from medical model to recovery-oriented model (Nelson et al., 2001). They found the most significant shift that occurred in the experience of recovery among consumers was from feeling powerless to feeling empowered. The informants attributed this to having choices, self-determination,

community integration, and resources. Empowering conditions included the individual's personal motivation, supportive relationships, responsive organizations and communities, social change, and social justice (Nelson, et al., 2001).

Although remission in symptoms is not a requirement for recovery, many consumers report that managing symptoms was essential. Individual symptom management varies greatly. People may achieve this through medication, therapy, or alternative methods of healing. Nevertheless, most consumers reported managing symptoms was an important aspect of recovery (Davidson, 2005).

A strong social support network is another important factor in recovery. Jacobsen and Greenly (2001) state that recovery is a social process; people need witnesses and support for their triumphs and failures. Various researchers have found for the importance of social supports, including mentorship as models for their recovery journeys (Davidson, 2005), friendship to reduce isolation (Ridgeway, 2001), and a strong social support network (Tooth, et al., 2003).

Meaningful activities and age-appropriate social roles are also important for the recovery process (Davidson, 2005; Noordsy et al., 2002). People need a sense of meaning and purposefulness in their lives and benefit by making worthwhile contributions to their community (Nelson et al., 2001). When people with mental illness begin taking part in valued leisure activities, such as vacations, this is a sign of health and recovery (Noordsy, et al., 2002). Finally, religion and spirituality are important factors in recovery. Whether it is the social support of a religious community or faith to get through difficult periods, some find it an indispensible component of recovery. Ridgway (2001) writes about recovery as a journey. She states that her subjects describe initially being stuck in "a lifetime of pills, shrinks, labels, powerlessness, and

hopelessness" (p. 337) and then progressing to a full and dynamic life. In this respect, the journey is much like a spiritual quest.

Some researchers have sought consumer definitions of recovery through content analysis of works written by people with mental illness (Andreasen et al., 2003; Ridgway, 2001). These studies undertook examination of existing accounts of personal stories and narratives. Andreasen and colleagues (2003) sought to determine how consumer-survivors define recovery and found the definition of recovery reported was on continuum from "medical model" to "psychiatric rehabilitation model" to "empowerment model."

The Psychiatric Rehabilitation definition of recovery maintains that although the illness is incurable, with rehabilitation, the person can return to some semblance of the life they had before they had the illness. Similar to the medical model, it assumes that the illness is chronic (Anthony, 1993), but people can learn to live well within the limitations of the illness. The empowerment model purports that mental illness does not have a biological foundation. Instead severe emotional distress is caused by numerous and unmanageable stressors (Andreasen et al., 2003). How a person responds to these stressors and how others respond to them will influence their recovery journey. With compassion, hope, and choice, the consumer can heal and resume his or her place in society avoiding the label of mental illness (Andreasen, et al, 2003). Andreasen and colleagues (2003) found that most consumer definitions of recovery fell somewhere between Psychiatric Rehabilitation and the empowerment model at a point they called "psychological recovery" (p. 588). Psychological recovery refers to establishing a fulfilling, meaningful, and positive sense of self, based in hopefulness and self-determination (Andreasen et al., 2003). These studies are important for clarifying the Recovery Perspective and Psychiatric Rehabilitation models; however, research appears to support a biological base for specific

psychiatric conditions such as schizophrenia (Fuller Torrey, 2006). In fact, recent studies on genetic theories, neurochemical theories, developmental theories, infectious and immune theories, and endocrine theories, are all supported by new bio-imaging techniques and have garnered tremendous support in the psychiatric community.

Impact of Mental Health Professionals on Recovery

Subjects of Tooth and colleague's (2003) study speak about the negative effects of medications and some health professionals' behavior on recovery. Nearly two-thirds of study participants reported that health professionals had a negative impact on their recovery. They reported that statements such as, "You can't," stripped them of any hope of getting better (Tooth et al., 2003). Mead and Copeland (2000), who contributed their personal narrative as both consumers and professionals, also addressed the nature of the therapeutic relationship and the need for changes in beliefs, attitudes, and practices. They described the necessity for practitioners to shift from treating consumers as patients or clients, to treating them as adult partners in decision-making. This question of practitioner's ability to accept and adopt a Recovery Perspective is central to this study.

Practitioners Adoption of a Recovery Paradigm

Development of Core Competencies

One of the ways in which mental health providers have attempted to respond to the Recovery Perspective has been through development of core competencies; they have established guidelines and standards for the field (Chinman, Young, Rowe, Forquer, Knight, & Miller, 2003). This is effective in improving services to the seriously mentally ill and others with medical and mental health disorders. Guidelines and standards call for "best practices" as defined by current scientific evidence, and in its absence, clinical judgment. In mental health, many

treatment protocols exist for individuals with serious mental illness, however studies reveal that adherence to these practices is low. Another way to improve care to the seriously mentally ill would be improving providers' core competencies (Chinman et al., 2003). Competencies refer to knowledge, skills, and attitudes providers hold. As opposed to guidelines or standards, competencies emphasize skills and values (Chinman et al., 2003).

Young and colleagues (2000) also developed a set of competencies for providers of services to people with serious mental illness. These emphasized concepts such as rehabilitation, self-help, client empowerment, and recovery. These are vital to high quality care for those with serious mental illness (Chinman, 2003). Table 1 presents core competencies across disciplines that serve seriously mentally ill adults and incorporate similar skills, knowledge, and attitudes. All disciplines are working to impart core competencies to new workers with varying degrees of success (Chinman et al., 2003).

Table I

Competencies across Disciplines

Discipline	**Competencies**
Psychiatrists	Patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, systems-based practice
Psychologists	Scientific foundations of psychology and research; ethical, legal, public policy/advocacy and professional issues; supervision; psychological assessment; individual and cultural diversity; intervention; consultation and interdisciplinary relationships; professional development ethical, legal, public policy/advocacy and professional issues
Psychiatric Nurse Practitioners	Health promotion, health protection; disease prevention and treatment (assessment, diagnosis of health status plan, implementation of treatment); practitioner-patient relationship; teaching/coaching function; professional role; managing and negotiating health care delivery systems; monitoring and ensuring quality health care practice; cultural competence
Psychiatric Rehabilitation Practitioners	Interpersonal competence; interventions, assessment, planning and outcomes; community resource competence; professional roles; systems competence, diversity
Social Workers	Palliative care, cultural competence, clinical practice

Psychiatric Treatments and Mental Health Workers

Currently, there are well-defined psychopharmacological and psycho-social interventions that improve outcomes for people with serious mental illness. There is also increasing agreement that care should be consumer-centered and include attention to recovery, rehabilitation, and consumer empowerment. There are effective treatments such as supported employment and family psycho-education that only reach a small number of individuals. A substantial number of

current providers and provider organizations do not possess necessary competencies. Further, professionals often have negative views of psychiatric rehabilitation, mutual support, and recovery; this affects the process of consumer-centered care (Hoge et al., 2005).

Mental Health Workers and the Recovery Perspective

Increasingly, consumers and entities that fund mental health treatment programs expect practitioners to be recovery-oriented in their practice with people with mental illness. Researchers led by Casper (2003; 2005; 2002), including Oursler (Caspar & Oursler, 2003; Casper, Oursler, Schmidt & Gill, 2002) and Bedregal and colleagues (2006) pioneered studies about the extent to which mental health workers from various professional disciplines adopt and practice according to recovery principles.

Staff expectations regarding recovery and people in recovery are an important part of this perspective (Bedregal et al., 2006). Studies have demonstrated that when mental health providers embrace many of the elements of recovery, including the need to rediscover or recreate a sense of self apart from the illness, they are also able to accept aspects of the changing role of the professional. They allow consumers to bear much of the responsibility for their own recovery and provide them choices about how this recovery will occur (Bedregal et al., 2006). Recovery-oriented staff members recognize the importance for consumers to give something back within their communities. In other words, these experiences promote a sense of citizenship and help mental health consumers take on meaningful roles (Bedregal et al., 2006). In contrast, Davidson and colleagues (2006) found staff had more difficulty endorsing concepts such as complex, non-linear processes of recovery. They also struggled with the notion that people can be in recovery while still experiencing symptoms of the illness.

Response to Training

Some researchers have examined the extent to which practitioners who are provided with educational interventions about the recovery model are able to adopt the recovery perspective (Bedregal et al., 2006; Felton, Barr, Clark, & Tsemberis, 2006; McVanel-Viney, Younger, Doyle & Kirkpatrick, 2006; & Meehan & Glover, 2009; Tsai, Salyers, & McGuire, 2011). These studies demonstrate that practitioners, when properly trained, are able to accept this model. Many of the principles of the recovery model, such as self-determination, supportive others, and hope, are consistent with practitioners' own codes of ethics and beliefs about practice. These studies also identify areas that practitioners struggle with in terms of embracing this philosophy.

These studies reveal areas in which practitioners resist the perspective such as being stuck with the belief that only they can determine which consumers are suited for treatment that incorporates recovery principles and those who were not. Some mental health providers wonder whether these principles can be effective with a consumer who could not admit to being mentally ill or with a consumer who was in crisis (Felton et al., 2006). Further, they may be uncertain about their role in relation to the consumer in a recovery-oriented paradigm. For example, who determines what are appropriate goals, the patient, or the practitioner? Mental health workers may also struggle with adopting a symptom dominant versus a holistic view of the consumer (Felton et al., 2006). These struggles belie an underlying lack of acceptance of the Recovery Perspective. McVanel-Viney and colleagues (2006) found that the major challenges to the adoption of a recovery-oriented system were a general lack of understanding and "buy-in." Internalized stigma towards the seriously mentally ill on the part of professionals may also be a barrier to embrace of the Recovery Perspective.

Stigma and Mental Health Treatment Providers

Stigmatizing attitudes towards the mentally ill can impede help seeking and adversely effect treatment for consumers (Fernando et al., 2010; Legere, 2007; Tooth et al., 2003). This coupled with the impact of the President's New Freedom Address (2003) declaring that all mental health services should be recovery oriented, a notion inherently de-stigmatizing, seems to have led to a burgeoning of interest in the attitudes of professionals and lay people towards the mentally ill (Arvaniti et al., 2009; Beltran et al., 2007; Chui & Chan, 2007; Fernando et al., 2010; Markstrom et al., 2009; Mehta et al., 2009; Pitre et al., 2007; Putman, 2008; Ross & Goldner, 2009; Schaefer et al., 2010; Vidha et al., 2008; Yamauchi et al., 2010). An interesting finding was that although one in three people were likely to experience mental illness at some point in their lifetime, stigma and negative attitudes toward mental illness were very prevalent (Putnam, 2008). Pre- and post-tests found that interventions geared to decrease stigma and negative attitudes were very effective (Mehta et al., 2009; Pitre et al., 2007).

Studies found that the most effective tool in the fight against stigmatization of the mentally ill was experience in the field, and subsequently knowing someone with a mental illness (Arvaniti et al., 2009; Beltran et al., 2007; Markstrom et al., 2009; Vibha et al., 2008; Yamauchi et al., 2010). Not surprisingly, students were more likely to hold negative views of the mentally ill than professionals were (Beltran et al., 2007; Fernando et al., 2010; Yamauchi et al., 2010). However on completion of training or fieldwork, these negative views diminished (Beltran et al., 2007; Yamauchi et al., 2010). Similarly, attendants on a psychiatric ward were more likely to have compassion for mentally ill individuals than non-psychiatric attendants were (Vibha, 2008). Medical students also held negative attitudes towards the mentally ill, in particular finding them blameworthy for their predicament (Fernando et al., 2010).

A review of the nursing literature on discrimination and negative attitudes toward the mentally ill identified three categories of professionals: those who stigmatize, those who were stigmatized, and those who fight to de-stigmatize individuals with mental illness (Ross & Goldner, 2009). Those who are stigmatized refer both to prosumers (professionals who are also consumers of mental health services) and those who feel stigmatized as professionals working with the psychiatric population. As such, the nursing profession has found that it will be necessary to modify training programs to modify beliefs and assumptions, and promote a commitment to cultural competence in mental health practice (Schaefer et al., 2010).

The Recovery Perspective and Psychiatric Rehabilitation challenge stigmatizing views about the seriously mentally ill. Recognizing the strong possibility for recovery and participants' rights to determine the course of their own treatment, are at odds with a marginalizing view of individuals with mental illness. Studies utilizing *the Recovery Knowledge Inventory* (RKI) (Bedregal, O'Connell & Davidson, 2006) and the *Psychiatric Rehabilitaiton Beliefs, Goals and Practices Scale* (PRBGPS) (Casper, 2005), looked at attitiudes of mental health practitioners towards the Recovery Perspective and the Psychiatric Rehabilitation treatment model. However, social worker's attitudes towards these models were not disaggregated from other mental health workers.

Mental Health Worker Practices and Knowledge of Recovery

The RKI was developed as part of a statewide program in Connecticut to render treatment facilities more recovery-oriented (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006). The task of this project was to teach the public sector workforce about recovery-oriented principles, values, and practices (Bedregal, O'Connell & Davidson, 2006). The authors recognized that recovery takes on a various meanings for different members of the psychiatric community from

consumers to staff to administrators to legislators. Consequently, these researchers integrated a long-established definition that acknowledged recovery as the termination of signs, symptoms, and illness related deficits, with the emerging definition of recovery, which focused more on civil liberties and membership in society for people experiencing serious mental illness (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005).

In addition to review of the literature and statistical evaluation of the instrument, the researchers consulted key stakeholders to determine which items to discard and which to retain. Initially the RKI was a 36-item instrument; however, the final version of the RKI contains 20 items. The RKI was the result of a literature review on recovery, consensus of experts in the field, and a preliminary empirical validation of the instrument.

This instrument allowed the researchers to analyze staff's understanding and attitudes about recovery. Four established dimensions in the instrument included roles and responsibilities in treatment, the non-linearity of the recovery process, the role of self-determination and peers in the recovery process, and expectations regarding recovery. The development of the RKI was an important step towards empirically evaluating the practice of recovery-oriented care among mental health workers. Outcomes of the Connecticut study confirmed that staff obtained the highest mean for dimension three, the roles of self-definition and peers in recovery. This suggested that staff endorsed the notion that consumers in recovery needed to develop a sense of self that went beyond the illness and the value of a peer support system in the recovery process. However, staff was less comfortable with the idea of determining realistic yet hopeful goals of treatment and recovery. Finally, staff had little knowledge about the non-linearity of the recovery process or that that recovery could occur with or without a reduction in signs and symptoms of illness. "Staff" in this study was not defined. Although social workers may have been included in

the study sample, they were not identified as such. This study might have included mental health practitioners of different disciplines including social work, but the professional characteristics of the sample is unknown.

Meehan and and Glover (2009) utilized the RKI to assess the effectiveness of a consumer-led recovery training program in Australia. Similar to findings in the US, they found that workers who received training showed significant improvements in recovery knowledge. Therefore, the RKI demonstrated transportability as it was useful in measuring change in an Australian sample.

Psychiatric Rehabilitation Worker Psychiatric Rehabilitation Practices

Casper (2005) developed the *Psychiatric Rehabilitation Beliefs, Goals, and Practices Scale* (PRBGPS), which he validated in three studies. The first, described the development of the scale to measure the beliefs, goals, and practices of staff members who worked with people with serious mental illness by surveying 190 mental health staff members (Casper, 2005). The second tested the reliability of the subscales included in the scale by surveying 469 mental health staff (Casper, 2005). In his third study, he looked at two issues: first, the relationship of consumer outcomes of quality of life, empowerment, and service satisfaction; and second, to determine if the scale was a valid measure of actual staff practice by showing the scales relationship to the consumer outcomes (Casper, Oursler, Schmidt & Gill, 2002). The first study resulted in the 26-item scale, which he tested for reliability using Cronbach's *Alpha* and achieved an alpha of .84 with the sample of International Association of Psychosocial Rehabilitation members surveyed. For the outcomes of the second study, the scale achieved a Cronbach *Alpha* of .68, which is a modest but acceptable *Alpha* level. Further, the three subscales for the instrument also demonstrated validity and reliability. The final study surveyed 58 voluntary IAPSRS members,

and 191 of the consumers with whom they worked. This study demonstrated that his instrument was a stable measure of practitioners' knowledge of some of the beliefs, goals, and practices endorsed by leading thinkers and researchers in Psychiatric Rehabilitation. In addition, it demonstrated significant association with the variance of consumer outcomes (Casper et al., 2002).

This instrument was also tested for sensitivity to change (Casper & Oursler, 2003). In other words, would this instrument be able to pick up changes in staff attitudes based on a training experience? It did prove useful to this end, and further, 301 practitioners surveyed in Pennsylvania demonstrated significantly higher scores on the post-test, indicating that training has a positive impact on embrace of the psychiatric rehabilitation model.

Casper (2005), surveyed a national sample of psychiatric rehabilitation professionals to determine their beliefs, goals and practices with regard to Psychiatric Rehabilitation using the PRBGPS. This study demonstrated that professionals exposed to key psychiatric rehabilitation theorists do endorse this model. Again, although some of the psychiatric rehabilitation professionals may have also been social workers, they were not identified as such. What was most important to the current study was that social workers were not studied as a unique population in any previous studies. This was particularly problematic, since social workers as a profession provide more mental health services than any other occupational group.

Gaps in the Literature

In summary, some research has been undertaken across disciplines that provide services to the seriously mentally ill to identify and disseminate core competencies to enhance services to this population. Although many core competencies exist, assessment of practitioner adoption of these core competencies has only begun. In social work in particular, there has not been a

concerted effort to ascertain social worker's acceptance of Psychiaric Rehabilitation or the Recovery Perspective.

Research that has examined practitioners' adoption of the recovery model is still new. A number of studies examined this from the standpoint of response to training. There have also been studies on Psychiatric Rehabilitation counselors' adoption of the recovery model (Casper, 2005). Social workers, who provide most of the care to this population (Kirk, 2005), have not been the subjects of research about their attitudes, beliefs, and practices of the Recovery Perspective or Psychiatric Rehabilitation.

Social workers provide the majority of services to seriously mentally ill adults, yet social workers are not represented in the literature assessing professional adoption and adherence to practices in these new paradigms. This dissertation research sought to fill that gap in the literature.

CHAPTER VI: METHODOLOGY

Statement of Purpose and Research Question

The purpose of this study was to determine the extent to which Masters level social workers, who have worked with the severely mentally ill in their professional capacity, endorsed a Recovery Perspective or adopted the Psychiatric Rehabilitation model in their work with these clients. Recovery is a formidable movement that is shaping mental health policy and treatment delivery. Social workers, the major professional group that serves people with mental illness, work in direct line positions, supervisory and administrative positions and, in some cases, state commissioners for mental health (Kirk, 2005). They have a considerable impact on the field. Given that research suggests that the relationship with a professional who endorses the Recovery Perspective is paramount in effecting recovery outcomes (Legere, 2007; Tooth et al., 2003), it was important to examine social workers' beliefs, attitudes, knowledge, and practices regarding the Recovery Perspective to determine the extent to which their practice reflected contemporary service expectations.

This study sought to answer the following questions: Did social workers adopt a Recovery Perspective in their work with individuals diagnosed with serious mental illness? Did they practice core competencies such as recognizing recovery readiness, honoring consumer self-determination, tolerating consumer risk taking, and recognizing the individual process of recovery? If so, which aspects of the Recovery Perspective were they more likely to embrace? Were they more likely to adopt a recovery model when consumers were high functioning? Did they work from a strengths-based rather than deficit-focused treatment model? Furthermore, did social workers adopt the Psychiatric Rehabilitation model in their work with consumers with serious mental illness?

There is a burgeoning of literature addressing the recovery perspective and mental health workers adoption of that perspective (Andreasen, Oades & Caputi, 2003; Bedregal, et al., 2006; Casper, 2005; Lieberman & Kopelowicz, 2002). However, social workers are noticeably absent from studies that addressed the adoption of recovery; other professional groups, such as psychiatric rehabilitation counselors, were represented in these studies (Casper, 2005). This study sought to fill that gap by focusing specifically on social workers treating people with serious mental illness.

Variables

People with serious mental illness as discussed in the introduction were defined as individuals who carried a diagnosis of schizophrenia, bi-polar disorder, major depressive disorder, anxiety disorder, or borderline personality disorder who experienced significant impairment in functioning because of the disorder. Independent variables for analysis included informational characteristics such as length of time in the field of mental health and level of education. Additional independent variables included support of clinical setting, type of community where the subject practiced, type of practice setting, theoretical frame of reference, and whether or not a respondent had a family member or close friend who suffered with mental illness. The two dependent variables for analysis included social worker knowledge and adoption of the Psychiatric Rehabilitation model and social worker knowledge and adoption of the Recovery Perspective. These dependent variables were measured using two existing scales: the *Psychiatric Rehabilitation Beliefs, Goals and Practices Scale* (PRBGPS) (Casper, Oursler, Schmidt & Gill, 2002) and the *Recovery Knowledge Inventory* (RKI) (Bedregal, O'Connell, & Davidson, 2006). Scores on the PRBGPS ranged between a low of twenty-six and a high of one

hundred and thirty, while scores on the RKI ranged from twenty to one hundred. Higher scores indicated greater acceptance of these perspectives.

The dependent variables measured subjects' alignment with the Recovery Perspective in mental health and practice that adhered to the Psychiatric Rehabilitation model. These were measured using the two instruments described, the *Psychiatric Rehabilitation Beliefs, Goals and Practices Scale* (PRBGPS) and the *Recovery Knowledge Inventory* (RKI) The former measured practice of the Psychiatric Rehabilitation model with questions about level of agreement with statements such as "My making choices for a person suffering from schizophrenia is the same as my making choices for a person who is not mentally ill." The RKI measured subjects' knowledge and adoption of the Recovery Perspective. It included responses to questions such as level of agreement or disagreement with items such as "The concept of recovery is equally relevant to all phases of treatment," or "It is often harmful to have too high of expectations for clients." I discuss these scales at length later in this chapter.

Theory/Model/Paradigm

Studies of mental health workers attitudes towards recovery are in their infancy (Casper, 2005, 2003, 2002; Bedregal, O'Connell, & Davidson, 2006; Chinman, Young, Rowe, Forquer, Knight & Miller, 2003; Young, Forquer, Tran, Starzynski, & Shatkin, 2000). Prior to this study, researchers had not measured social workers' attitudes towards or their adoption of psychiatric rehabilitation. I conceptualized this study according to the psychiatric rehabilitation model as developed by William Anthony (1993) and the recovery perspective defined by consumers of mental health treatment who recovered and went on to write about their experiences in the mental health system and their recovery experiences. Key factors in the Recovery Perspective parallel many of those in Psychiatric Rehabilitation. These promote the idea that with hope,

meaning, and purpose in life, people with serious mental illness can and do recover (Anthony, 1993; Noordsy, Torrey, Mueser, Meade, O'Keefe & Fox, 2002). The literature suggests that professional attitudes towards recovery greatly influence recovery outcomes (Legere, 2007; Tooth, Kalyanasundaram, Glover & Momenzadah, 2003). Psychiatric Rehabilitation principles support client's recovery aspirations. Chapter Three on mental health theory and Chapter Five, a review of the empirical literature, expanded these concepts.

Quantitative Methodology

The Instruments

In order to study this topic, I employed a post-positivist methodology that entailed quantitative data gathering strategies. Quantitative methodologies allows researchers to measure the characteristics of a sample population and, in this instance, to what extent they endorsed recovery concepts and psychiatric rehabilitation practice (Grinnell & Unrau, 2005). This study built on current knowledge in the field of serious mental illness by summarizing data from a random sample of participants, and thereby approximating the attitudes in the population as a whole. In this case, the sample consisted of NASW members in New York State practicing with individuals with serious mental illness. The literature supports the idea that mental health professionals can learn from training on the Psychiatric Rehabilitation model and Recovery Perspective (Bedregal et al., 2006; Felton, Barr, & Clark, 2006; McVanel-Viney, Younger, Doyle & Kirkpatrick, 2006). However, no research exists about social workers' current beliefs, attitudes, skills, knowledge, and practices regarding these two perspectives.

Quantitative methods have their limitations, some of which are threats to internal validity. For example, the principle of reactivity refers to subjects' tendency to respond in a particular way because they know they are being watched. There is the risk that under observation,

respondents will answer questions in a manner aligned with social desirability. In this study, a worker might have been aware of the mandate that all mental health agencies should be recovery-oriented. They could answer questions to conform to these expectations, even if they did hot hold these beliefs. For this reason, both established instrument protocols I utilized in this study contained reverse scoring for a number of the items (Grinnell & Unrau, 2005).

Reductivism refers to complex concepts reduced to common observable phenomena that may distort or oversimplify the actual concept (Grinnell & Unrau, 2005). In this case, quantitative methods may not have captured the subtleties of practitioner's attitudes and practices. Finally, the principle of determinism is the problem that positivist research is designed to make generalizations that do not actually reflect subjects' beliefs, goals and attitudes (Grinnell & Unrau, 2005).

Hypotheses

This study consisted of informational questions, and two established scales. It sought to answer the following primary questions: Did social workers embrace a Recovery Perspective in their work with seriously mentally ill adults? Did social workers adopt a Psychiatric Rehabilitation model in their work with seriously mentally ill adults? Secondary questions were plentiful and hypotheses follow.

Null hypotheses and hypotheses:

1. There is no relationship between years experience in the field and adoption of the psychiatric rehabilitation beliefs, goals and practices scale (PRBGPS) and the recovery knowledge inventory (RKI).

- There is a positive relationship between years experience in the field and adoption of the psychiatric rehabilitation beliefs, goals and practices scale (PRBGPS) and the recovery knowledge inventory (RKI).

2. There is no relationship between degree status and adoption of psychiatric rehabilitation or knowledge of the recovery movement as demonstrated by scores on the PRBGP scale and the RKI.

- There is a positive relationship between higher degree status and adoption of psychiatric rehabilitation or knowledge of the recovery movement as demonstrated by scores on the PRBGP scale and the RKI.

3. There is no relationship between practicing in an urban setting and adoption of the psychiatric rehabilitation model or recovery as demonstrated by scores on the PRBGP scale and the RKI.

- There is a positive relationship between practicing in an urban setting and adoption of the psychiatric rehabilitation model or recovery as demonstrated by scores on the PRBGP scale and the RKI.

4. There is no relationship between practicing in a more restrictive setting such as a clinic or private practice and adoption of psychiatric rehabilitation or recovery as demonstrated by scores on the PRBGP scale and the RKI.

- There is a positive relationship between practicing in a less restrictive setting such as a clinic or private practice and adoption of psychiatric rehabilitation or recovery as demonstrated by scores on the PRBGP scale and the RKI.

5. There is no relationship between having a friend or family member who suffers with mental illness and greater adoption of psychiatric rehabilitation or recovery as demonstrated by scores on the PRBGP scale and the RKI.

- There is a positive relationship between having a friend or family member who suffers with mental illness and greater adoption of psychiatric rehabilitation or recovery as demonstrated by scores on the PRBGP scale and the RKI.

6. There is no relationship between being a social worker guided by a theory that finds fault in the environment (behavioral, family systems, and socio-cultural theories) and greater adoption of psychiatric rehabilitation or recovery as demonstrated by scores on the PRBGP scale and the RKI.

- There is a positive relationship between being a social worker guided by a theory that finds fault in the environment (behavioral, family systems, and socio-cultural theories) and greater adoption of psychiatric rehabilitation or recovery as demonstrated by scores on the PRBGP scale and the RKI.

7. There is no relationship between working at an agency that embraces the recovery perspective and greater adoption of psychiatric rehabilitation or recovery as demonstrated by scores on the PRBGP scale and the RKI.

- There is a positive relationship between working at an agency that embraces the recovery perspective and greater adoption of psychiatric rehabilitation or recovery as demonstrated by scores on the PRBGP scale and the RKI.

8. High scores on the PRBGP scale will not predict high scores on the RKI.

- High scores on the PRBGP scale will predict high scores on the RKI.

I assumed understanding the relationships among these variables would facilitate a greater knowledge of when and under what conditions social workers endorsed a Recovery Perspective and Psychiatric Rehabilitation model. As stated, I selected two existing and well-known instruments for use in this study described in detail below.

The Psychiatric Rehabilitation Beliefs Goals and Practices Scale (PRBGPS)

The first existing instrument I employed, the *Psychiatric Rehabilitation Beliefs Goals and Practices Scale*, (PRBGPS) (Casper & Oursler, 2003) (See Appendix 1), addressed subjects' adherence to psychiatric rehabilitation-oriented beliefs, attitudes, and practices as opposed to a deficit focused treatment model (See Appendix 1). Before development of the PRBGPS, there was no reliable measure of practitioners' knowledge of this practice model (Casper, 2005). The PRBGPS filled that gap in instrumentation and enabled researchers to measure variance of practitioner's knowledge and embrace recovery.

They conducted early field studies of this instrument that demonstrated that the PRBGPS was a reliable, valid, and sensitive instrument to measure beliefs, goals, and practices of psychiatric rehabilitation professionals. In addition, the instrument produced three sub-scales. The first sub-scale, the Consumer Driven Paradigm reflected the Psychiatric Rehabilitation model and Recovery Perspective. A core belief of Psychiatric Rehabilitation is that personal values, preferences, and expectations of individuals with serious mental illness are in line with healthy functions which should be honored, developed, and should direct the rehabilitation process. Honoring healthy functioning leads to achievement of other rehabilitation goals.These include building new skills, a sense of competence, a sense of agency, and overall recovery (Casper, 2005). Goals and practices focus on successful integration into the community through

an emphasis on a place to live, competitive employment, lessening poverty, increasing social networks outside the mental health system, and relying less on symptom reduction.

Sub-scale II is entitled Deficit Focused/Staff Directed Paradigm, and contains items inconsistent with Psychiatric Rehabilitation and recovery. It focuses on symptoms, illness, and a dire prognosis formerly associated with chronic mental illness. The core belief here is that serious mental illness causes permanent limitations to functioning and will require unremitting involvement and support by educated professionals. The primary goals from this perspective are symptom control, perhaps sheltered employment, and relapse prevention.

Subscale III is entitled Consensus Guideline/ Empirical-Based Practices. These include generally accepted practices in the field. This examined practitioners' comfort with actual consumer directed practices

To summarize, Casper (2005) created the *Psychiatric Beliefs, Goals, and Practices Scale* (PRBGPS) with three sub-scales. This three-factor model includes the Consumer Driven Paradigm, Deficit-Focused/ Staff Directed Paradigm, and Empirical Based/Consensus Guideline Practices (Casper, 2005). I contacted the authors of this instrument for permission to use it for this study and received email permission to use it for the dissertation.

The Recovery Knowledge Inventory (RKI)

The second scale I utilized in this study was the *Recovery Knowledge Inventory* (RKI), (Bedregal, et al., 2006) (See Appendix 2). This scale measured subject's knowledge of and adherence to recovery principles across twelve domains: recovery readiness, self determination, risk taking, managing symptoms, citizenship, individual process, involvement in meaningful activities, redefining self, hope, incorporating illness, non linear process, services are not enough, and supportive others.

To integrate these dichotomous definitions into a single tool to assess staff adoption of recovery-oriented care, recovery was broadly conceptualized as involving "a re-definition of illness which sees mental illness as one aspect of a multi-dimensional sense of self capable of identifying, choosing and pursuing self generated and meaningful goals beyond or despite continuing to suffer the effects or side effects of chronic mental illness (Bedregal et al., 2006, p. 97)." Based on this definition, the authors identified several domains as most salient in providing services to consumers with serious mental illness. These were consumer directedness, the individual nature of recovery, cultural competence, self-determination, strength based care, choice and risk taking, illness and symptom management, incorporation of illness into one's sense of self, involvement in meaningful activities, overcoming stigma, redefining self, hope, and the non-linear nature of the recovery process (Bedregal et al., 2006). Four subscales were maintained.

Bedregal and colleagues (2006) collected baseline data for 169 staff from nine different agencies that make mental health and substance abuse treatment services available in the state of Connecticut. The psychometric properties of the RKI were explored in different ways. Content validity was assessed by sampling items from different recovery domains discussed in the literature (Bedregal et al., 2006). Internal consistency reliability was assessed using Cronbach's *Alpha*, and internal structure of the instrument was evaluated by using Principle Component Analysis (PCA).

The factors, dimensions, or subscales that the analysis produced were labeled a) roles and responsibilities in recovery, b) non-linearity of the recovery process, c) the roles of self-definition and peers in recovery, and d) expectations regarding recovery. The variance accounted for by these four dimensions was 50%, and broke down as follows: Roles and responsibilities

included seven items related to risk taking, decision making, and the roles and responsibilities of people in recovery as well as mental health providers, and explained 17% of the variance. The second dimension, the non-linearity of the recovery process, explained 13% of the variance. The third dimension, roles of self-definition and peers in recovery, explained 12% of the variance. The fourth dimension, expectations regarding recovery, explained 8% of the variance. Reliability analysis, Cronbach's *Alpha*, estimated for the four components, .81, .70, .63, and .47, respectively.

This instrument had important implications for social workers because it could identify the aspects of recovery-oriented care that were least familiar to providers at this time, and subsequently identify direction for training to improve competency in the area of recovery-oriented care. The researcher contacted the authors of this instrument for permission to use it for this study and received email permission to use it for this dissertation.

Study Design

Recruitment Strategy for Study Sample

The subjects of this study were social workers in New York State who were National Association for Social Workers (NASW) members and currently working with people with serious mental illness in any setting. With the support of NASW, the research study subjects were a random sample of 3,000 social workers drawn from the NASW member list. Those who screened eligible and agreed to respond constituted the sample. I anticipated that 200 MSW social workers, screened for their eligibility as current mental health workers, would complete the survey. In fact, 442 MSW social workers who stated they were current mental health workers completed and returned surveys by postal mail. This was an anonymous postal survey and no identifying information about study participants was collected.

Data Collection Procedures

This study was a voluntary, anonymous postal survey about social workers attitudes towards adoption of a Recovery Perspective in their work with individuals with serious mental illness. With NASW support and approval, the Association supplied mailing addresses of 3,000 individuals of its membership. A recruitment letter (see Appendix 5) announced the study and invited social workers who work with individuals working with mental illness to participate. The recruitment letter explained the purpose of the study and the procedures subjects would follow if they chose to participate. I followed the initial recruitment letter with another mailing to the same membership sample. This mailing contained a passive consent form and the survey instrument and invited the social workers to participate in the study by filling out the survey and returning it in the self-addressed, stamped envelope. If the potential subjects agreed, they read the consent form and proceeded to fill out the 53-item survey. Participants returned it in the self-addressed stamped envelope. If they did not consent, they were instructed to discard the survey. A "Thank You" page at the end of the survey also provided links to Internet web sites about recovery-oriented treatment in mental health and the NASW New York Chapter website.

Social workers working with people with serious mental illness who completed the survey had the opportunity to participate in a lottery for $100 gift card to American Express. To enter the lottery, participants were asked to send me a "Survey Completion" card with their survey (See Appendix 8). The consent form indicated that their participation in the lottery would compromise their anonymous participation in the study.

Each questionnaire should have taken approximately 30 minutes to complete. The survey included two instruments. The first two were the Casper and Oursler (2003) *Psychiatric Rehabilitation Beliefs, Attitudes and Practices Scale* (PRBGPS) and the Bedregal, O'Connell

and Davidson's'(2006) *Recovery Knowledge Inventory* (RKI). As stated earlier, I had previously sought and received consent to use these instruments (See Appendix 9). The scales employed five point Likert scales, from Strongly Disagree (one) to Strongly Agree (five). I collected informational data through forced-choice questions including educational background; years in mental health practice; and the fact of having a family or close friend with mental illness. As anticipated, the sample was large enough so these variables could not identify any individual person.

Other Human Subjects Protection Issues

There were no direct benefits for subjects participating in this study. However, the lessons learned may be of considerable value to the field of social work. There were no known risks associated with participation in this study.

This was a voluntary and anonymous study. I manually input data into SPSS-PC in a secure password protected computer. Returned surveys were stored in a locked file cabinet in my home office. The only other people who had access to the data set were members of my dissertation committee. All findings reported here were aggregated. The findings of this study are reported here in a dissertation, which partially meets the requirements for the degree of Ph.D. in Social Welfare.

Conclusion

This study sought to examine social workers' beliefs, attitudes, skills, and practices among people with serious mental illness. Of particular interest was their adoption of both the Recovery Perspective and the Psychiatric Rehabilitation model. In addition, I was interested in understanding how certain variables related to these practices. Quantitative methodology was a logical choice in order to understand the relationships between the variables identified and to

determine under what conditions social workers embrace these models. I hoped that these methodologies would facilitate a greater understanding of current social work beliefs, attitudes, knowledge, skills, and practices with severely mentally ill adults.

CHAPTER VII: STUDY RESULTS

Descriptive Findings

The question posed in this study was to what extent did mental health social workers in New York State who were members of the National Association of Social Work (NASW) hold values and beliefs consistent with the Recovery Perspective and Psychiatric Rehabilitation models in their practice with seriously mentally ill people. It also sought to determine what factors influenced these social worker's decisions in practice with this population. The study employed a paper and pencil survey mailed to a random sample of 3,000 National Association of Social Work (NASW) members that I purchased from the NASW from their list of New York State members. Four hundred and forty one subjects returned usable surveys.

The description of the sample population included the following variables: years of experience in the field; educational level; type of community; type of setting; the circumstance of having a close friend or family member with mental illness; subject's theoretical frame of reference; and whether or not the agency in which subjects practiced adhered to the Recovery Perspective. After inputting data into SPSS, I ran frequency distributions of these characteristics to describe the sample population and examine variables for later use in multiple regression statistical analyses to test hypotheses.

Characteristics of the Study Participants

Most of the social workers who responded to this survey were experienced practitioners. Sixty-seven percent (n=293) reported they had practiced in the field for ten years or more, with 30% (n=144) reporting up to 20 years of social work employment. The modal response to the question, "How many years have you practiced in social work?" was "over 10 years," or between 10 and 19 years 37% (n=293).

The modal response to the question regarding subject's highest academic degree was the Masters of Social Work, with 58% (n=253). Although more than one-third of the subjects 36% (n=158) reported they had completed Post Masters Certificates, only 5% (n = 21) had a doctorate and 1% (n= 5) a postdoctoral certificate. The subjects practiced in three types of communities, with more than half 56% (n=237) practicing in urban settings. Of the remaining practitioners, 37% (n=156) worked in the suburbs and only 7% (n=28) in rural communities.

The survey queried whether subjects practiced in less restrictive settings, such as clinics or private practice, or more restrictive settings, such as inpatient hospitals, day hospitals, or continuing day treatment programs. The vast majority of subjects reported practicing in less restrictive settings as their primary or secondary place of employment. Forty-four percent (n=195) were in private practice and 34% (n=150) reported they practiced in clinics. As for practice in more restrictive environments, 11% (n=47) worked in inpatient facilities; 8% (n=36) worked in continuing day treatment programs; and 2% (n=10) in day hospitals. These findings were consistent with the policies that call for least restrictive treatment settings described in earlier chapters. Because some subjects checked more than one option, the total percentage was greater than 100%. This suggests that professional social workers who practice with seriously mentally ill patients may encounter them in different types of settings.

Because practitioners vary in the theoretical framework that guides their practice, the survey offered seven options for this variable. The first three, biological, psychodynamic, and cognitive behavioral are in some circles considered frames of reference that find fault in the individual (Alloy et al., 1999). In contrast, behavioral, family systems, socio-cultural and others place the genesis of serious mental illness on factors outside of the individual. Only eleven percent (n=47) reported practicing from a biological frame of reference. In responses to this

question, 42% (n=178) reported practicing from a psychodynamic perspective, and 47% (n=200) reported an allegiance to the cognitive behavioral model. On the other hand, 12% (n=52) reported practicing from a behavioral perspective, 22% (n=95) from a family systems perspective, 17% (n=74) from a socio-cultural perspective and 21% (n=88) reported practicing from an Other perspective. When subjects selected "Other," they included such categories as body-oriented, gestalt, humanist, and holistic models. In total, 309 endorsed an allegiance to a frame of reference that blamed psychiatric illness on forces outside of the individual. Again, some respondents selected more than one category, and therefore the total percentage is greater than 100%. This may suggest that some MSW social workers practice from an eclectic perspective.

Finally, the survey queried whether the agency where the subject practiced was in accord with a Recovery Perspective. Responses were problematic, because 24% (n=81) of the respondents skipped this question. Upon further examination, it was apparent that the question was not clearly articulated. If a respondent worked at more than one facility or had a private practice in addition to their agency based work, they might not have known how to respond. It is also possible that subjects did not respond to this question because they only engaged in private practice. Ultimately, 86% (n=290) were able to answer unequivocally, thus, the data was analyzed with this caveat.

Almost two-thirds 61%, (n=282) reported they had a friend or family member who suffered with mental illness, while 39% (n=167) reported that they did not. However, one respondent wrote in "everyone does, depression is a mental illness", which suggests that subjects may have used a broader definition of "mental illness" than the diagnostic categories included in

this study's definition of "serious mental illness." Characteristics of the subjects are summarized in Table II.

Table II

Characteristics of Participants (N=441)

Characteristic	*n*	%
Years in social work practice		
Less than one year	14	3
Between one and 5 years	81	19
Between 6 and 9 years	49	11
Ten years or more	293	67
Highest academic degree		
Masters in social work	253	58
Post-masters certificate	158	36
Ph.D. or D.S.W.	21	5
Post doctoral certificate	5	1
Type of Community		
Urban	237	56
Suburban	156	37
Rural	28	7
Type of Setting		
In-Patient	47	11
Day Hospital	10	2
Continuing Day Treatment Program	36	8
Clinic	150	34
Private Practice	195	44
Other	152	35
Family Member or Close Friend with SMI		
Yes	262	61
No	167	39
Theoretical Frame of Reference		
Biological	47	11
Psycho-dynamic	178	42
Cognitive Behavioral	200	47
Behavioral	52	12
Family Systems	95	22
Socio-cultural	74	17
Other	88	21
Agency Embrace of Recovery Perspective		
Yes	249	74
No	41	12
Not applicable	47	14

Mean and Standard Deviation of the Dependent Variables

Mean scores and standard deviations of the two dependent variables were calculated. On the PRBGPS, the mean score was 90.00 with a standard deviation of 9.06. Sub-scales of this instrument were also calculated. The Consumer Driven Paradigm sub-scale had a mean of 33.00 with a standard deviation of 4.6; the Deficit focused, Staff-directed paradigm sub-scale had a mean of 38.00 with a standard deviation of 5.25; the Practice Questions sub-scale had a mean of 19.2 with a standard deviation of 3.08.

The Recovery Knowledge Inventory had a mean of 68.50 with a standard deviation of 8.81. The sub-scales for this instrument included the Roles and Responsibilities in Treatment sub-scale which had a mean of 27.24 with a standard deviation of 4.13; the Non-linearity of Treatment sub-scale had a mean of 14.84 with a standard deviation of 3.76; the Self Determination and Peers in Recovery sub-scale had a mean of 20.54 with a standard deviation of 2.6; and the Expectations Regarding Recovery sub-scale had a mean of 5.84 with a standard deviation of 1.87. These scores appear in Table III below.

Table III

Mean Scores and Standard Deviation of Dependent Variables

Scales and Sub-scales	Mean	SD
Psychiatric Rehabilitation Beliefs Goals and Practices	90.00	9.06
Consumer Driven Paradigm	33.00	4.6
Deficit-Focused Staff-Directed Paradigm	38.00	5.25
Practice Questions	19.2	3.08
Recovery Knowledge Inventory	68.50	8.81
Roles and Responsibilities in Treatment	27.24	4.13
Non-linearity of recovery	14.84	3.76
Self determination and peers in recovery	20.54	2.6
Expectation regarding recovery	5.84	1.87

Multiple Regression Analysis

The question posed in this study was the extent to which National Association of Social Work (NASW) social workers adhered to a recovery perspective and practiced from a psychiatric rehabilitation model in their work with the seriously mentally ill, and what were factors that influenced their decisions. These questions were answered by employing multiple regression analysis. Multiple regression is a statistical method for studying the relationships between a single dependent variable and one or more independent variables (Allison, 1999). Multiple regression can be used for predictive and/or causal analysis. In predictive analysis, the objective is to develop an equation to make predictions about the dependent variable. On the other hand, in a causal study, the independent variables are explored as the causes of the

dependent variable (Allison, 1999). The purpose of this study was to understand NASW social worker's adoption of the Recovery Perspective and practice of the psychiatric rehabilitation model. It sought to determine whether independent variables, such as years employed in the field; credentials; community in which employed; type of setting in which employed; the experience of having a family member or close friend with serious mental illness; theoretical frame of reference; or agency adoption of the recovery perspective, effected the dependent variable, and if so, what is the magnitude of that effect.

Table IV

Dependent Variable- Recovery Knowledge Inventory (RKI)

Independent Variable	Unstandardized Regression Coefficient	Significance	
1-5 years	3.7	.20	
6-9 years	1.3	.68	
10-20 years	3.9	.19	
Over 20 years	5.3	.08	Trend
PMSW	.05	.97	
PhD/DSW	2.7	.30	
PPHD/PDSW	14.8	.10	
Suburban	.29	.80	
Rural	2.0	.35	
Day hospital	-2.4	.43	
CDTP	1.8	.31	
Clinic	1.6	.22	
Private Practice	-2.0	.12	
Other	.92	.50	
No family member	.44	.69	
Psychodynamic	-.23	.06	Trend
Cognitive behavioral	1.0	.39	
Behavioral	-3.5	.09	
Family systems	-3.0	.03	Significant
Socio-cultural	.46	.79	
Other	4.3	.00	Significant
No agency embrace	.05	.94	
R2	.16		
Adjusted R2	.09		
Standard errors	8.74		

Note: Mean for this scale was 68. N=310. Significance on ANOVA was .001.

Social workers who had been practicing for Over Twenty Years had a higher average RKI level; however, this finding was not statistically significant. Other variables in the category of years in practice were not significantly related to RKI. Level of credentials yielded no significant findings. Credentials, community, and type of setting yielded no significant findings. Social workers who reported that they subscribed to a psychodynamic theoretical frame of reference had lower RKI levels, but the finding was not statistically significant. On the other hand, social workers whose theoretical frame of reference was reported as Family Systems or Other showed a significantly higher score on the RKI than those who selected the reference category, Biological. The unstandardized regression coefficient for the Family Systems variable was -3.0, and it was statistically significant at the .05 level. This would indicate that the mean level of knowledge of recovery for those who reported Family Systems as their theoretical orientation is three points lower than the level of recovery knowledge for those in the reference category, Biological. Other had an unstandardized coefficient of 4.3, and it was statistically significant at the .01 level. Thus, the mean level of knowledge of recovery was 4 points higher for those who identified as Other than the mean level for those in the reference category. Cognitive behavioral, behavioral, and socio-cultural produced no significant findings. Agency adoption of the model showed no significant findings. These findings can be seen in Table IV above.

Table V

Dependent Variable-RKI—Subscale 1 – Non-Linearity of the Recovery Process (NLRP)

Independent Variable	Unstandardized Regression Coefficient	Significance	
1-5 years	1.3	.34	
6-9 years	.91	.53	
10-20 years	1.80	.20	
Over 20 years	2.62	.06	Trend
PMSW	2.16	.76	
PhD/DSW	.49	.70	
PPHD/PDSW	-1.33	.67	
Suburban	.47	.37	
Rural	.47	.63	
Day hospital	-.21	.88	
CDTP	.65	.44	
Clinic	.46	.44	
Private Practice	-1.08	.06	Trend
Other	-.05	.93	
No family member	.22	.67	
Psychodynamic	-.38	.52	
Cognitive behavioral	.74	.18	
Behavioral	-.20	.04	Significant at the .05 level of confidence
Family systems	-1.13	.08	Trend
Socio-cultural	.01	.99	
Other	1.26	.12	
No agency adoption	-.17	.03	Significant at the .05 level of confidence
R2	.108		
Adjusted R2	.035		
Standard errors	4.13		

Note: Mean for the scale was 27.20. N=318. Significance on ANOVA was .07.

The first subscale, which examined social workers' knowledge and adoption of the non-linearity of the recovery process, rendered interesting results. Once again, social workers who had been practicing with the population for over twenty years had a higher score on the RKI-NLRP, but this finding was not statistically significant. On the other hand, social workers in Private Practice had a lower score on the RKI-NLRP although this finding was not significant. One theoretical frame of reference, Behavioral, showed an unstandardized regression coefficient of -.20 which is significant at the .05 level. This indicated that those who selected Behavioral had a mean of .20 less than those who did not select behavioral. Those who worked for agencies that did not adopt the model had a mean of -.17 at a .05 level. Thus, the mean score of agency adoption of the recovery model was 17 points lower than the mean level of knowledge of recovery for those whose agencies did adopt the model. These findings appear in Table V.

Table VI

Dependent Variable- RKI Subscale 2—Roles and Responsibilities in Recovery (RRR)

Independent Variable	Unstandardized Regression Coefficient	Significance	
1-5 years	.65	.60	
6-9 years	.13	.92	
10-20 years	.73	.56	
Over 20 years	1.48	.23	
PMSW	-.14	.76	
PhD/DSW	1.4	.21	
PPHD/PDSW	.08	.98	
Suburban	-.37	.44	
Rural	.46	.60	
Day hospital	.30	.98	
CDTP	.30	.70	
Clinic	.50	.35	
Private Practice	-.19	.72	
Other	.56	.32	
No family member	.07	.88	
Psychodynamic	-.89	.09	Trend
Cognitive behavioral	-.24	.63	
Behavioral	-1.21	.14	
Family systems	-1.44	.02	Significant at the .05 level of confidence
Socio-cultural	-.37	.62	
Other	2.34	.000	Significant at the .01 level of confidence
No agency embrace	-.09	.77	
R2	.16		
Adjusted R2	.09		
Standard errors	3.7		

Note: Mean for this scale was 15. N=317. Significance on ANOVA was .001.

For the subscale, Roles and Responsibilities in Recovery (RKI-RRR), only theoretical frame of reference showed significance. Psychodynamically oriented NASW social workers had a lower RKI-RRR level but this finding was not statistically significant. At a .05 level of significance, family systems therapists had a mean of 1.4 lower than non-family systems therapists did. This would indicate that those who selected family systems as their theoretical orientation were 1.4 points lower than the mean level of knowledge for those who did not select family systems as a theoretical framework. Those who selected Other as their frame of reference had an unstandardized regression coefficient of 2.34 at the .01 level, which would indicate that NASW social workers who identified as Other in their theoretical frame of reference had a 2.34 higher mean level of knowledge than those who did not select other. These results appear in Table VI.

Table VII

Dependent Variable-RKI—Subscale 3—The Role of Self Determination and Peers in Recovery (SDPR)

Independent Variable	Unstandardized Regression Coefficient	Significance	
1-5 years	.27	.74	
6-9 years	-.52	.56	
10-20 years	.06	.94	
Over 20 years	-.02	.97	
PMSW	.00	.99	
PhD/DSW	.60	.42	
PPHD/PDSW	-6.9	.008	Significant at .01 level of confidence
Suburban	.17	.59	
Rural	.49	.42	
Day hospital	-1.0	.22	
CDTP	.59	.24	
Clinic	-.09	.79	
Private Practice	-.41	.24	
Other	.09	.79	
No family member	-.08	.78	
Psychodynamic	-.58	.10	
Cognitive behavioral	-.03	.13	
Behavioral	.50	.95	
Family systems	-.45	.25	
Socio-cultural	.11	.81	
Other	.30	.48	
No agency adoption		.80	
R2	.101		
Adjusted R2	.027		
Standard errors	2.5		

Note: Mean for the scale was 20.63. N=318. Significance on ANOVA was .11—not a significant model.

For the Role of Self Determination and Peers in Recovery (RKI-SDPR), only one variable showed significance. Subjects who reported that they had earned a postdoctoral training certificate (n=5), had an unstandardized regression coefficient of -6.9 at the .01 level. This would indicate that the mean level of knowledge of the role of self-determination and peers in recovery for those with postdoctoral training certificates was 6.9 points lower than the mean level of knowledge for those without postdoctoral training certificates. These findings appear in Table VII.

Table VIII

Dependent Variable-RKI—Subscale 4—Expectations of Recovery (ERR)

Independent Variable	Unstandardized Regression Coefficient	Significance	
1-5 years	1.1	.07	Trend
6-9 years	.81	.22	
10-20 years	.99	.12	
Over 20 years	.96	.13	
PMSW	-.00	.97	
PhD/DSW	.31	.57	
PPHD/PDSW	-3.6	.01	Significant at .01 level of confidence
Suburban	.02	.94	
Rural	.52	.25	
Day hospital	-.75	.24	
CDTP	.02	.97	
Clinic	.36	.18	
Private Practice	-.37	.17	
Other	.30	.31	
No family member	.10	.67	
Psychodynamic	-.19	.47	
Cognitive behavioral	.27	.26	
Behavioral	-.51	.21	
Family systems	.08	.79	
Socio-cultural	.36	.32	
Other	.72	.02	Significant at the .05 level of confidence
No agency adoption	.26	.08	Trend
R2	.11		
Adjusted R2	.04		
Standard errors	1.9		

Note: Mean for the scale was 5.9. N=322. Significance on ANOVA was .068.

Three variables were noteworthy for the subscale Expectations of Recovery (RKI-ERR). People in the field only 1-5 years had a higher RKI-ERR level, but this finding was not statistically significant. An unstandardized regression coefficient of -3.6 at the .01 level of significance for postdoctoral respondents indicated that for postdoctoral respondents the mean level of recovery knowledge was 3.6 points lower than for non-postdoctoral respondents. On the other hand, at the .05 level of significance, respondents who reported Other as their theoretical frame of reference had a mean level of recovery knowledge of .72 points greater than respondents who did not select Other as their theoretical frame of reference. These findings appear in Table VIII.

Table IX

Dependent Variable-Psychiatric Rehabilitation Beliefs, Goals and Practices Scale (TPRBGPS)

Independent Variable	Unstandardized Regression Coefficient	Significance	
1-5 years	4.50	.14	
6-9 years	3.62	.26	
10-20 years	4.0	.20	
Over 20 years	5.81	.06	Trend
PMSW	.24	.84	
PhD/DSW	.58	.82	
PPHD/PDSW			
Suburban	1.6	.18	
Rural	3.63	.10	
Day hospital	4.0	.22	
CDTP	4.08	.03	Significant at the .05 level of significance
Clinic	.59	.65	
Private Practice	-3.7	.00	Significant at the .01 level of significance
Other	.98	.46	
No family member	1.08	.33	
Psychodynamic	-2.32	.061	Significant at the .05 level of significance
Cognitive behavioral	1.31	.27	
Behavioral	-1.7	.38	
Family systems	-.87	.95	
Socio-cultural	1.7	.29	
Other	4.28	.00	Significant at the .01 level of significance
No agency embrace	.46	.51	
R2	.18		
Adjusted R2	.11		
Standard errors	8.67		

Note: Mean for the scale was 90.14. N=290. Significance on ANOVA was .000.

On the PRBGPS, there were several interesting findings. Once again, only the variable Twenty or More Years in the Field had a higher PRBGPS level, however, this finding was not statistically significant. Those with fewer years in the field showed no significance in either

direction. Credentials and Community in which Practice Occurred showed no significance either way. Type of setting, however, did show significance. Those who practiced in a Continuing Day Treatment Program (CDTP) had a regression coefficient of 4.08 at a .05 level of significance. This indicated that subjects who worked in a CDTP had a mean of 4.08 points higher on the psychiatric rehabilitation beliefs goals and practices scale than those who do not. Those who practiced in Private Practice had an unstandardized regression coefficient of -3.7 at a .01 level of significance, which indicated that their mean PRBGPS level was 3.7 points lower than the mean PRBGPS level for the reference group. Other types of settings showed no significant findings. The situation of having a family member with or without serious mental illness was not significant. Theoretical frame of reference was once again significant. As with the RKI, those who were psychodynamically inclined had a lower PRBGPS mean than the reference group at a .05 level of significance, while those who reported Other as their theoretical frame of reference had a higher PRBGPS mean than the reference group at a .01 level of significance. As seen in Table IX, the mean level of knowledge, beliefs, goals, and practices of the psychiatric rehabilitation model for those who selected psychodynamic as their theoretical frame of reference was 2.3 points lower than the mean level for those who did not select psychodynamic, while the mean level of knowledge, beliefs, goals, and practices of the psychiatric rehabilitation model for those who selected Other was 4.28 higher than the means for those who did not select Other as their theoretical frame of reference. Agency adoption of the model showed no significance. See Table IX for these findings.

Table X

Dependent Variable- PRBGPS Subscale—Consumer Driven Paradigm (CDP)

Independent Variable	Unstandardized Regression Coefficient	Significance	
1-5 years	2.9	.05	Significant at the .05 level of significance
6-9 years	2.3	.14	
10-20 years	2.3	.13	
Over 20 years	3.3	.03	Significant at the .05 level of significance
PMSW	.35	.54	
PhD/DSW	.18	.89	
PPHD/PDSW	-2.1	.64	
Suburban	.54	.33	
Rural	1.5	.16	
Day hospital	1.3	.44	
CDTP	2.7	.00	Significant at the .01 level of significance
Clinic	-.09	.89	
Private Practice	-1.0	.08	Trend
Other	.63	.34	
No family member	-.09	.87	
Psychodynamic	-1.3	.03	Significant at the .05 level of significance
Cognitive behavioral	.85	.15	
Behavioral	.17	.86	
Family systems	.11	.87	
Socio-cultural	1.5	.06	Trend
Other	1.6	.05	Significant at the .05 level of significance
No agency embrace	-.28	.41	
R2	.17		
Adjusted R2	.10		
Standard errors	4.3		

Note: Mean for the scale was 33. N=310. Significance on ANOVA was 000.

For the subscale that measured adoption of the consumer driven paradigm, beginning level social workers (1-5 years) and seasoned social workers (over twenty years) demonstrated knowledge of the model with a significance of .05. Those who reported being in the field 1-5 years had an unstandardized regression coefficient of 2.9 at the .05 level. This indicated that

those with 1-5 years in the field had a mean recovery knowledge level that was 2.9 points above that for the reference group. Similarly, workers in the field over twenty years had an unstandardized regression coefficient of 3.3 at the .05 level, indicating that they had a mean of 3.3 units higher than that of social workers in the reference group. Those in the middle demonstrated no significance. Once again, Credentials and Community demonstrated no significant outcomes. People practicing in Continuing Day Treatment Programs had an unstandardized regression coefficient of 2.7 at the 0.1 level indicating that those practicing in CDTP had a mean 2.7 points higher than the mean knowledge level of those in the reference group. Those in Private Practice showed a trend toward rejecting the model. People practicing in other settings showed no significance. Psycho-dynamically oriented social workers had a mean -1.3 point lower than that for the reference group at the .05 level of significance. Social workers who reported Other had a mean 1.6 units above the mean for social workers in the reference group at the .05 level of significance. Socio-cultural therapists had a higher PRBGPS-CDP level; however, this finding was not statistically significant. Other variables showed no significance. These findings appear in Table X.

Table XI

Dependent Variable-- TRBGPS Subscale—Deficit Focused Paradigm (DFP)

Independent Variable	Unstandardized Regression Coefficient	Significance	
1-5 years	.34	.85	
6-9 years	-.35	.85	
10-20 years	.48	.80	
Over 20 years	.65	.71	
PMSW	.10	.90	
PhD/DSW	.07	.96	
PPHD/PDSW	.12	.98	
Suburban	.96	.17	
Rural	.99	.44	
Day hospital	1.7	.36	
CDTP	1.0	.35	
Clinic	2.5	.75	
Private Practice	-1.9	.01	Significant at the .01 level of significance
Other	-.25	.76	
No family member	.34	.69	
Psychodynamic	-.29	.70	
Cognitive behavioral	1.0	1.5	
Behavioral	-1.8	1.5	
Family systems	.20	.23	
Socio-cultural	-.03	.03	Significant at the .05 level of significance
Other	1.6	.09	Trend
No agency embrace	.50	.24	
R2	.09		
Adjusted R2	.01		
Standard errors	5.3		

Note: Mean for the scale was 38. N=309. Significance on ANOVA was .30.

In examining the magnitude of social worker rejection of the deficit-focused model, two items emerged as significant. Private practitioners had an unstandardized regression coefficient of -1.9 at the .01 level of significance. Socio-cultural therapists had an unstandardized regression coefficient of -.03 at the .05 level of significance. See Table XI for these findings.

Table XII

Dependent Variable-- PRBGPS Subscale—Practice Questions (PQ)

Independent Variable	Unstandardized Regression Coefficient	Significance	
1-5 years	.65	.52	
6-9 years	1.01	.35	
10-20 years	.46	.66	
Over 20 years	1.07	.30	
PMSW	-.22	.58	
PhD/DSW	.03	.97	
PPHD/PDSW	.62	.84	
Suburban	.18	.65	
Rural	.67	.37	
Day hospital	-.01	.99	
CDTP	.21	.73	
Clinic	.50	.26	
Private Practice	-.70	.10	
Other	.47	.32	
No family member	.43	.25	
Psychodynamic	-.74	.08	Trend
Cognitive behavioral	-.53	.19	
Behavioral	.10	.88	
Family systems	-.35	.46	
Socio-cultural	.21	.72	
Other	1.3	.01	Significant at the .01 level of significance
No agency embrace			
R2	.11		
Adjusted R2	.04		
Standard errors	3.0		

Note: Mean for the scale was 19.18. N=312. Significance on ANOVA was .06.

In terms of actual consumer focused/ psychiatric rehabilitation practices, psychodynamically oriented professionals had a lower level on the PRBGPS-PQ. However, it was not statistically significant. Subjects who selected Other as their frame of reference had a regression coefficient of 1.3 which was significant at the .01 level of significance. These findings appear in Table XII.

CHAPTER VIII: STUDY IMPLICATIONS FOR SOCIAL WORK EDUCATION AND RESEARCH

Discussion

This study sought to determine the extent to which professional mental health social workers in New York State who were members of the National Association of Social Work (NASW) adhered to the beliefs, goals, and practices associated with a Recovery Perspective and Psychiatric Rehabilitation model in their work with seriously mentally ill consumers. It also sought to understand what factors influenced these social worker's ability to endorse these perspectives in their work with this population. The study employed a paper and pencil survey mailed to 3,000 National Association of Social Work (NASW) members. This was a random sample purchased from the NASW from their list of members in New York State. Four-hundred-and-forty-one subjects returned usable surveys.

NASW social workers who had been practicing in the field of mental health for over twenty years know about, held beliefs about, and demonstrated attitudes endorsing both the Recovery Perspective and Psychiatric Rehabilitation at a greater rate than less experienced social workers did. This was an interesting finding. I expected newer social workers entering the profession at a time when a recovery-oriented perspective is mandated in New York State would be more familiar with these models and endorse them. Studies show that mental health professionals, such as psychiatric rehabilitation workers, and undifferentiated workers, respond favorably to training on the Psychiatric Rehabilitation model and Recovery Perspective (Casper, 2003; Felton et al., 2006; Bedregal et al., 2006). This raised the question whether social workers entering the field were receiving training in these perspectives. If not, the implications for practice were to determine how new social workers were trained and educated to work with

individuals with serious mental illness. Because social workers are the professional group that provide the majority of services to this population (Kirk, 2005), this is of grave importance.

Another possible explanation for this finding was that more experienced workers had witnessed more recovery stories. One of the travesties of the social work profession is that it is the least experienced workers who work with consumers in need of the most professional intervention (Stride, 2006). In his commentary, Stride (2006) recounts his personal experience with the mental health system. When his son had his first psychiatric break, there were three key players: his son, himself, and the social worker who just graduated from school. None of these actors knew what would transpire "with the passage of time." If this explanation proves accurate in future studies, the implications for the field are of great importance. At this point in the history of mental health treatment, there are financial and workforce incentives for direct service social workers to leave direct agency practice and take on positions such as supervisors, directors, and administrators once they achieve a significant level of experience. Private practitioners with established practices who generally work with clients with less severe pathology enjoy greater hourly wages, lower caseloads, and more freedom and flexibility. Supervisors, directors, and other social workers in administrative positions earn more, have private offices, and have more power and control over their day-to-day activities. The low level of mental health reimbursement does not encourage older, more experienced clinicians in front line worker positions. However, if seasoned professionals were more able to work within the framework of these important practice principles, it would be important to understand more about how their positive perspective develops over time and determine ways that enable them to work shoulder-to-shoulder with less experienced social workers.

Another interesting finding in this study was that a majority of NASW social workers more readily endorsed the subscale PRBGPS-CDP, the consumer-driven paradigm. However, there are indications they would not always operationalize it in their practice. PRBGPS-CDP measures one's beliefs, goals, and practices with regard to a consumer-driven paradigm. The consumer-driven paradigm suggests that consumers guide every aspect of their own treatment to achieve goals of their choosing; these are practices consistent with the Psychiatric Rehabilitation model (Casper & Oursler, 2002). Social work work subjects clearly identified with the values embedded in the psychiatric rehabilitation model. However, their psychiatric rehabilitation practice behaviors, as evidenced by their lower scores on the PRBGPS-PQ subscale, lagged behind.

Although a majority of NASW social workers appeared comfortable with aspects of the ideals of the recovery perspective, it appeared that many of these NASW social workers are still uncertain about their roles in the context of practice within these two models.

Study Hypotheses

In sum, these multiple regressions answered questions in the seven hypotheses put forth. Original Hypotheses:

1. There is a positive relationship between years experience in the field and adoption of the *Psychiatric Rehabilitation Beliefs, Goals, and Practices* scale (PRBGPS) and the *Recovery Knowledge Inventory* (RKI).

Workers with more experience in the field a demonstrated higher scores on the PRBGPS (Casper, 2005) and the RKI (Bedregal et al., 2006), than workers with less years in the field. Several of the subscales for both of those dependent variables, the RKI-NLRP, RKI-ERR and the PRBGPS-CDP, also evidenced higher scores. The non-linear recovery process also evidenced

higher means. This was also true for the subscale expectations regarding recovery and the consumer driven paradigm.

2. There is a positive relationship between degree status and adoption of psychiatric rehabilitation or knowledge of the recovery movement as demonstrated by scores on the PRBGP scale and the RKI.

Academic credentials demonstrated a relationship to the dependent variables. On two subscales, the RKI-SDPR and the RKI-ERR, there appeared to be a negative relationship between highest degrees held (Post -doctoral training certificates) and the RKI-SDPR and the RKI-ERR.

3. There is a positive relationship between practicing in an urban setting and adoption of the psychiatric rehabilitation model or recovery as demonstrated by scores on the PRBGP scale and the RKI.

The community in which one practiced did not show a relationship to the dependent variables PRBGPS or the RKI. In fact, it did not demonstrate significance or even a higher score on any of the subscales.

4. There is a positive relationship between practicing in a less restrictive setting such as a clinic or private practice and adoption of psychiatric rehabilitation or recovery as demonstrated by scores on the PRBGP scale and the RKI.

Rather than look at restrictive versus non-restrictive settings, each setting category was run as a dummy variable with in-patient hospital as the reference variable. Although many of these settings did not show significance, those who worked at Continuing Day Treatment Programs, demonstrated higher scores on the scales for the PRBGPS and the PRBGPS-CDP. Likewise, those who reported working in private practice settings demonstrated lower scores on

the PRBGPS, on several sub-scales including the PRBGP-CDP on which they demonstrated lower scores, and on the PRBGP-DFP, where significance was found. The RKI-NLRP also showed lower scores indicating a negative relationship.

5. There is a positive relationship between having a friend or family member who suffers with mental illness and greater adoption of psychiatric rehabilitation or recovery as demonstrated by scores on the PRBGP scale and the RKI.

The situation of having a friend or family member with SMI did not emerge as a significant variable or even show an inclination towards higher scores.

6. There is a positive relationship between being a social worker who is guided by theory that traditionally found fault in the individual (biological, psychodynamic, or cognitive behavioral theories) and greater adoption of psychiatric rehabilitation or recovery as demonstrated by scores on the PRBGP scale and the RKI.

Due in part to a small sample size, rather than looking at theories that find fault in individuals as opposed to those that find fault for illness in factors outside the individual, dummy variables were created for each theoretical perspective, and there was some significance found. Another reason to examine theoretical frame of reference in this manner had to do with moving past the reductionist models and trusting that the current emphasis on integration would be prevalent in social workers of different theoretical frames of reference. Thus, biologically oriented social workers were the reference group. On the RKI, RKI-RRR, PRBGPS, PRBGP-CDP and PRBGP-PQ, psychodynamically oriented individuals had a lower average on these outcomes.

In contrast, subjects who identified as being guided by an "Other" theoretical frame of reference demonstrated significantly high means on the RKI, on the RKI-RRR, on the RKI-ERR,

on the PRBGPS, on the PRBGP-CDP, on the PRBGP-DFP, and on the PRBGPS-PQ. Other frames of reference such as family systems and behavioral theories also had higher mean scores on some of the scales. Family systems showed a significant negative relationship to the RKI and a negative trend to the RKI-NLRP. Similarly, those who selected behavioral theories as their frame of reference showed a significant negative relationship with respect to RKI-NLRP.

7. High scores on the PRBGP scale will predict high scores on the RKI.

In this case, the hypothesis was supported.

In summary, some social work practitioners seem to identify with the values and ideals of the Recovery Perspective and Psychiatric Rehabilitation model. However, they did not follow through with practice consistent with these perspectives. It is not surprising that social workers endorse the principles of Psychiatric Rehabilitation and the Recovery Perspective, because both have many areas of agreement with social work values and the NASW *Code of Ethics*. However, practices such as encouraging self-direction and risk taking, are not conducive to practice in the litigious, blaming, and risk-averse culture in which social workers practice. It may also be that social workers need extensive experience with people with serious mental illness in order to take these risks. Over time, they may see recovery in action and grow less protective of this vulnerable population of clients.

Discussion

This study indicated that the settings in which social workers practiced made a difference in their adoption and adherence to a recovery orientation and Psychiatric Rehabilitation. Social workers practicing in Continuing Day Treatment Programs (CDTP) were more inclined to adopt these approaches than private practitioners who were less inclined to endorse these models. I had speculated that social workers who worked with higher functioning and clients who evidenced

higher levels of recovery would be more likely to endorse the models. I assumed they would have been more likely to see recovery in action. Likewise, I expected that those working with more seriously ill individuals might be more cynical about recovery. In contemplating an outcome that indicated the opposite, it may be that staff working in Continuing Day Treatment Programs in the New York area has been exposed to evidence-based practices in accord with the Psychiatric Rehabilitation model and Recovery Perspective. Therefore, it would be reasonable to expect that they would be the group to have more knowledge and embrace of the models as they did.

Psycho-dynamically oriented social workers were less likely to endorse the models, while those who practiced from theoretical frames of reference outside of traditional ones were more likely to accept them. Psychodynamically oriented social workers place an emphasis on insight and symptoms. In addition, they have an historical allegiance with the medical model. Therefore, it is not surprising that they might have more difficulty integrating a recovery perspective in their work. At the same time, the term "psycho-dynamic" is not a precise term. Respondents self-reported subscribing to a psychodynamic perspective, and the study did not take into account the different subsets of psychodynamically oriented social workers. It does appear, however that social workers who practice from less traditional frames of reference were less entrenched in the hierarchical, medical model, and more open to adopt a Recovery Perspective.

Although it is known that in the field today practitioners are more inclined to incorporate numerous theoretical models, psychodynamically oriented social workers often believe insight is a necessary pre-condition for recovery. This is not consistent with a recovery-oriented perspective. The necessity of developing insight is an important concept that runs counter to both the Recovery Perspective and Psychiatric Rehabilitation. Similarly, it is not surprising that social

workers in clinics, private practice, and other settings were less inclined to endorse the models than those working in restrictive settings, such as a continuing day treatment program. Although people in the less restrictive settings see more "recovered" people, since recovery oriented care is a mandate of public agencies in New York State, those practicing in agency-based settings, such as continuing day treatment, are more likely to be exposed to recovery-oriented theorists and psychiatric rehabilitation oriented models. In addition, it is possible that training initiatives have focused on mental health workers in these more restrictive settings.

This study's findings were consistent with those of Bedregal and colleagues (2006) in their Connecticut study. They found that staff obtained the highest mean score of 4.15 on component three, the roles of self-definition and peers in recovery. This indicated that providers could appreciate the need for the person in recovery to develop a positive self-identity beyond that of "mental patient" and the importance of peers in recovery. Following close behind with a mean score of 3.88 were roles and responsibilities in recovery. This indicated that staff also appreciated the importance of differentiating the roles and responsibilities of each party in the treatment and rehabilitation process. The third highest mean score of 3.13 was for component four, expectations regarding recovery. This seemed to indicate that staff was less able to develop realistic, yet hopeful, expectations of their clients. Finally, the lowest mean score of 2.78 rested on component two, the non-linearity of the recovery process. This suggested that staff had the least knowledge about the nature of the recovery process, including the non-linear nature of recovery. In addition, they failed to understand that a consumer could be symptomatic and still progress with recovery. In addition, Bedregal and colleagues found they did not envision multiple pathways through which people could recover including both informal treatment and rehabilitation settings (Bedregal, et al. 2006).

Overall, there were a surprising lack of significant findings, probably due to small sample size; those that did emerge were not always in support of the initial hypotheses. As discussed, psycho-dynamically oriented social workers, who I anticipated would endorse the models because of their focus on development of insight resulting in recovery, demonstrated lower scores on both models. Those who worked in less restrictive environments, and therefore presumably with more individuals with higher rates of recovery were anticipated to endorse the models. However, they were more likely to demonstrate lower scores on the models. In retrospect, these are not surprising findings.

Implications for Practice

Unquestionably, the Recovery Perspective informs the direction of current practice for people with serious mental illness (Anthony, 2011; Davidson, et al., 2010). In addition, both the scholarly literature and the voices of consumers strongly support the notion that working with a clinician who practices from a Recovery Perspective greatly enhances the possibility of recovery for the consumer (Legere, 2007; Tooth et al., 2003). It is not enough for a practitioner to support the values of these models; they must also be able to operationalize them into their work with clients who may appear vulnerable to them.

Those who self-reported as psycho-dynamically oriented social workers showed lower scores on both models, and a substantial proportion (42%,n=178) of the New York State NASW social workers who responded to this study reported practicing from a psycho-dynamic frame of reference. This represents a large segment of the mental health work force in social work and does not bode well for their adoption of recovery-oriented practices, assuming they are practicing with seriously mentally ill consumers. Again, the definition of "psycho-dynamic" is multi-faceted which this survey did not account for. In contrast, a much smaller number of subjects

(21%, *n*=88) reported practicing from an "Other" frame of reference. These included a range of practice models, such as body-oriented, gestalt, humanist, and holistic therapies. These practitioners demonstrated higher scores suggesting allegiance to the Recovery Perspective and Psychiatric Rehabilitation models in their work. Private practitioners demonstrated lower scores on the models. Forty-four (*n*=145) reported practicing in private practice settings, while 8% (n=36) report practicing in Continuing Day Treatment Programs. Those practicing in Continuing Day Treatment Program demonstrated higher scores on the models. It is also noteworthy that the longer subjects were in the field, the more likely they were to score higher on the models. Many studies have demonstrated the efficacy of training to influence acceptance of the Recovery Perspective. These outcomes suggest a need to train new social workers about the recovery model. Frankly, it is not enough to promote recovery values, but an educational goal in preparing professionals must help new workers learn to act on those values. This is critically important for social workers, many of whom will work with seriously mentally ill consumers.

Limitations of Study

This study had several significant limitations, for example, as for the question, "agency embrace of recovery paradigm," although the literature supports the effects of this variable, I was inclined to drop the data from the study. Many subjects checked private practice as the only or secondary practice setting, and there was no option of "Other." Thus, many people responded that they worked in more than one practice setting. I did not anticipate the proportion of social workers whose careers would cover such a variety of settings. The question may have confused subjects, and there was a large amount of missing data for this variable. No relationships were identified with regard to the community in which the social worker practiced. Rather than accept that there is no relationship, this may also be indicative of a sampling error. More than half of the

sample reported practicing in an urban environment. A larger sample may have yielded different results. Another limitation of this study is that I failed to collect demographic data because I wanted to make the study as non-intrusive as possible. This resulted in my being unable to determine if there were relationships between demographic variables and my outcomes of interest.

Conclusion

Historically, the care and treatment of individuals with serious mental illness has undergone four major shifts. In the mid-1800s, moral treatment took place in asylums. In the 1890s, the mental hygiene movement moved treatment to mental hospitals and clinics. By the period between 1955 and 1970, mental health care moved into neighborhoods with the community mental health movement. Treatment sought to provide skills building and environmental buttresses to people with serious mental illness. As such, there was a national trend towards recovery-oriented treatment. In fact, in 1999, the New York State Commissioner on Mental Health urged that all mental health programs should be recovery oriented.

This was a challenge for the professional mental health community. Many theories exist to explain and provide for the treatment of mental illness, and the two that have been most prevalent are the biological and the psychodynamic. The psychiatric rehabilitation model, which emerged in the 1980s, provided an opportunity for joining and enhancing these two models. Psychiatric Rehabilitation, the practice approach or means to affecting the vision of the Recovery Perspective recognized bio-psycho-social and spiritual causes of mental illness. It focused skills building and buttressing the environment to help people with serious mental illness to achieve goals of their choosing and live lives of hope, meaning, and purpose.

Professionals, many working in agency based settings, are also influenced by their host setting's response to this change in the focus of practice. How an agency perceives and responds to these changes has an influence on how an individual professional responds to these changes in practice. Further, how a professional experiences changes in their role within the agency will have a strong effect on the success of implementing these changes in culture, philosophy, and practice.

A review of the literature demonstrated that unlike the Kraepelinian pessimistic view of recovery from serious mental illness, the vast majority of individuals with serious mental illness do recover and/or improve. In the 1980s, as a response to both the research that proved this assertion and a burgeoning of literature written by and about people with mental illness speaking of their own recoveries and the abuses they experienced in the mental health system, the recovery movement emerged. This movement began to redefine the concept of recovery, and insisted that clients, now called consumers, have an active role in determining their own treatment course.

In spite of tremendous political support for this movement, the adoption of these principles in practice has been slow. A burgeoning of literature has begun to address practitioners' embrace of these models, however, social workers, who provide the majority of services to this population, were not previously studied. This dissertation sought to fill that gap in the literature.

Despite the limitations of this study, there were some compelling findings. It is apparent that psychodynamically oriented social workers are not as likely to adhere to a recovery model as social workers who identify their practice as non-traditional. These practices included body oriented, Gestalt, holistic, or eclectic approaches. Social workers practicing in settings that

are more restrictive were more likely to encounter Psychiatric Rehabilitation and recovery oriented principles in their place of practice. Therefore, it appeared they knew more and had beliefs more consistent with both models.

Recommendations for Further Study

This study has several implications for social work education and future research. I have organized them around five topics: issues for social work education, the impact of theory, transportability, issues for professional training, and a discussion of other measures that might help learn how workers make decisions when they work with people with serious mental illness. The first, issues for social work education, addresses the apparent disparity between the ideals of social workers new to the field and their reported practices. The second, the impact of theory, speaks to psycho-dynamic theory and the current lack of clarity regarding how professional social workers understand this practice theory. Transportability refers to transporting evidence-based practices from the controlled research environment to the tumultuous practice setting. These issues have important implications for professional training. This requires exploration of the needs of new social workers employed in mental health facilities, in particular the way that the cultures of these facilities may influence adoption of the Recovery Perspective and Psychiatric Rehabilitation.

Implications for Social Work Education

Although NASW social workers practicing in the field over twenty years evidenced greater embrace of the ideals and practices of the Recovery Perspective and Psychiatric Rehabilitation, newer social workers did not demonstrate the same endorsement of these beliefs, attitudes, and practices. This study found that newer social workers, while apparently exposed to the ideals of these models, were not mastering the skills necessary to put this knowledge into

practice. Although it may seem logical that social workers in the field longer would align with older role definitions and a medical model of recovery, this was not the case. While it seems reasonable to assume that more recent social work graduates would be exposed to cutting-edge initiatives in the field in their curriculum in social work Masters' programs, it is possible that social work educators and programs are not up-to-date about new theories and practices. Recent theoretical models have been reductionist while older theoretical models were more comprehensive more aligned with the potential for greater recovery outcomes. Many prospective employers have dropped the question about theoretical frame of reference when interviewing new graduates, because the responses are consistently minimalist and unsatisfactory. More experienced practitioners could have had more robust education about theoretical models or might have witnessed more recovery outcomes in their tenure. Future research needs to determine where the breakdown is in mastering theory, and why recent graduates are not learning about complex theories guiding their practice with the Recovery Perspective and Psychiatric Rehabilitation practices. Although New York State promotes both, in addition to the evidence-based practices that support them, it may be the State has not been aggressive enough in promoting them among social work educators. The initiatives they have sponsored may not be reaching a large enough pool of educators to have an impact.

Impact of Training

As discussed in the Review of the Empirical Literature, researchers have examined the extent to which practitioners who are provided educational interventions about the recovery model are able to adopt the Recovery Perspective (Bedregal et al., 2006; Felton, Barr, Clark, & Tsemberis, 2006; McVanel-Viney, Younger, Doyle & Kirkpatrick, 2006; & Meehan & Glover, 2009; Tsai, Salyers, & McGuire, 2011). These studies demonstrate that practitioners, when

properly trained, are able to accept these models. However, social workers, the mental health professionals most likely to encounter this population (Kirk, 2005) may not have received equivalent training. If they have, the effects of such training have not appeared in the research literature. The researchers who developed the instruments used in this study were particularly interested in whether or not training influenced goals, beliefs, and practices related to recovery and Psychiatric Rehabilitation. They are available for social work educators and evaluators to use to determine whether their educational and training initiatives are working.

The existing studies have found the principles of the recovery model, such as self-determination, supportive others, and hope, were consistent with mental health practitioners' own codes of ethics and beliefs about practice (Bedregal et al., 2006; Felton, et al., 2006; McVanel-Viney et al., 2006; Meehan & Glover, 2009; & Tsai, et al., 2011. This study found that social workers also endorsed the ideals of the Recovery Perspective and Psychiatric Rehabilitation. However, although this study demonstrated some allegiance to these models, it did not show overwhelming support, particularly in terms of practices. Future studies need to translate ideals into actions through education, and then assess whether training and education have the same positive impact on social workers as was demonstrated for other mental health professionals.

Transportability

NASW and other mental health professional associations are currently establishing core competencies that practitioners should have before entering the field. In the field of social work, these competencies are organized around palliative care, cultural competence, and sound clinical interventions. Palliative care, soothing or addressing symptoms, is contra-indicated in Psychiatric Rehabilitation. This notion of maintenance rather than recovery is not consistent with the

Recovery Perspective. On the other hand, cultural competence, a concept that addresses reducing stigma, is very much in agreement with both models. Similarly, interventions that promote the process of recovery link both models. There is consensus that specific evidence-based practices that support recovery-oriented practice are important for treating people with serious mental illness. There have been a numerous studies on transportability of evidence-based practices (Leadbeater, 2010; Ogden, Karki, Stegenborg-Teigen, 2010; Dattilio, Edwards & Fishman, 2010; McHugh & Barlow, 2010; & Schoenwald & Hoagwood, 2001). Problems relate to a lack of similar contextual features between research and practice settings. Factors such as intervention characteristics, practitioner characteristics, organizational characteristics, service system characteristics eventuate in disparities between ideal settings and real-life agency conditions. Findings suggest that sufficient resources, strong collaborative relationships, availability of programs, and enthusiasm are factors that could narrow this gap.

An important issue for further research concerns how social workers compare with other disciplines that serve severely mentally ill consumers in their embrace of these models. Of particular importance are disciplines that have higher status in treatment settings than social workers. Psychiatrists are regularly chiefs of programs providing services to the seriously mentally ill; it is important to study how psychiatrists and social workers fare in comparison with one another in endorsing of these models. An implication for social work education can also be how to work within these ideals when others, perhaps with more power and status, may not be practicing from these ideals. An important question remains unanswered: What does it mean to "manage up" and advocate for a more democratic and consumer centered treatment facility?

The Impact of Theory

Theoretical frame of reference was another variable that demonstrated significance for identification with these models. Forty-two percent of the NASW social workers surveyed selected "psycho-dynamic" as their theoretical frame of reference. As a cohort, these subjects demonstrated a negative relationship to endorsement of these models. What is broadly called "psycho-dynamic theory" has changed considerably since its inception by Freud in the early 20th century. It would have been less surprising if there were no significant findings given the broad definition of psychodynamic theory at this time in history. Since theoretical frame of reference seems to influence endorsement of these models, future studies should examine what social workers mean when they report practicing from this theoretical perspective, as well as what they mean by the other perspectives. I suspect that qualitative inquiry would yield more integrated and comprehensive practice perspectives than was obtained through this study. Further, it might highlight gaps in theoretical knowledge, which could have important implications for how to effect greater adoption of practices across the field of social work.

Implications for Professional Training

Another independent variable that showed no significant relationship to the models was an agency's adoption of practice from a Recovery Perspective. In addition to clarifying the confusion regarding place of practice for those who practiced in more than one setting, future studies may consider expanding the question to ascertain other important information related to agency culture. For example, if the agency does endorse the Recovery Perspective, do respondents feel this is due to ideals or economic necessity? This could have tremendous implications for whether or not social workers at these agencies would endorse these models themselves. People tend to consider change undertaken due to economic necessity rarely to be in

the interest of consumers (Holbrech, 2006). The reverse is also true, when change comes about motivated by ideals, people are more likely to feel enthusiastic and work collaboratively. Further, if the agency does adopt the models, what supports have they provided to staff to facilitate role transition? The results of this study suggest a call to action for New York State to fund appropriate training initiatives for mental health workers in this State.

Implications for Future Research

Future studies may wish to expand on the vignette instrument in its early stages of development (See Appendix 3). An instrument that utilizes case examples may enhance understanding decision making on the part of social workers regarding beliefs about client recovery readiness. Vignettes provide descriptions of concrete situations. Research suggests that they are a means of producing more valid and reliable measures of respondent opinion than the more abstract opinion questions (Alexander & Becker, 1978). The vignette instrument begun for this study provided a range of situation characteristics, thereby reducing the number of vignette situations necessary for inclusion. Questions following the vignettes include a scaling question and two decision-making questions. Further development of this instrument would be an important next step in understanding what makes social workers comfortable practicing from a Recovery Perspective and what are their reservations.

In conclusion, several issues emerge as relevant for further study. These include issues related to social work education, the impact of theory, transportability, issues for professional training, and the development of a short vignette instrument to examine how social workers are making decisions about the Recovery Perspective.

Appendix 1

Psychiatric Rehabilitation Beliefs, Goals, and Practices Scale

Name: _____ Date:_____

Below is a list of 26 items dealing with various aspects of psychiatric rehabilitation. Please read each one carefully, and decide the degree to which you either AGREE or DISAGREE with the item. Use the scale below to rate each item by placing the scale number of your response in the box to the RIGHT of each item. Use the 3 rating if you are UNDECIDED and ON THE FENCE about a particular item. Please complete all items. Thank you!

1	2	3	4	5
Totally Disagree	Disagree Somewhat	Undecided: On the fence	Agree Somewhat	Totally Agree

1	Support development and environmental modifications may be more important than skill training in the long run for helping mentally ill persons achieve success in community integration.	
2	When developing a mentally ill person's rehabilitation plan and goals, I am guided primarily by a good assessment of his/her current mental status.	
3	I can usually judge how well a client will do at work or school settings by how well he/she does in his/her residence.	
4	PR is a consultative process in which the client should always discuss his/her decisions with the counselor before making them.	
5	Helping mentally ill people fashion a new , positive self image is a viable , long term PR goal.	
6	A mentally ill person's housing, work, and education should be in the same settings as persons who do not have a mental illness.	
7	When exploring potential residences for a mentally ill person, I rely on the person's housing preferences to direct the search.	
8	I'm not comfortable with a client that I serve joining a consumer-run self help group.	
9	People with mental illness need more protection from society than help to participate in it.	
10	My making choices for a person suffering from schizophrenia is the same as my making choices for a person who is not mentally ill.	
11	PR professionals should be as concerned with clients' quality of life as with their symptoms.	
12	One consequence of having a major mental illness is that people tend to lack personal preferences.	

13	**Because of the stress associated with it, working competitively should probably not be a goal for many mentally ill people.**	
14	**Assisting a person with mental illness to live alone in their own home is a proper PR goal so long as the person's symptoms are stable.**	
15	**A rehabilitation plan to help a mentally ill person go to work should always include gradual, incremental steps in order to reduce stress and maximize skill acquisition.**	
16	**Real recovery from mental illness often includes exposing a mentally ill person to the risks of relapse and failure.**	
17	**Providing supports to the mentally ill in their jobs or residences should try to be time limited so that they don't become too dependent on the supports.**	
18	**Educating mentally ill people about their illness, its symptoms, and their medication's benefits and side effects, is a good way to encourage cooperation with treatment.**	
19	**If given the opportunity, people with a major mental illness would choose the same kind of things any of us would want.**	
20	**I like to have a client's preferences and choices direct every aspect of the rehabilitation process, even where and when I intervene.**	
21	**I prefer a situational assessment to a global one to plan a client's skill training program.**	
22	**The outcomes achieved from very individualized PR services are often not worth the high cost and extreme complexity of providing them.**	
23	**Competitive employment is a proper goal so long as the mentally ill person has had prior competitive work experience.**	
24	**An overall goal of PR is to assist mentally ill people in developing their preferences and skills in reference to where they want to live, work, and socialize.**	
25	**Having a mental illness means in part that the capacity to learn and grow are greatly diminished**	
26	**A good rehabilitation plan identifies the person's greatest problems and weaknesses.**	

Appendix 1 Continued

PRBGP Scale Scoring Key

Item #	Reverse Scored (R)
1	
2	**R**
3	**R**
4	**R**
5	
6	
7	
8	**R**
9	**R**
10	
11	
12	**R**
13	**R**
14	**R**
15	**R**
16	
17	**R**
18	
19	
20	
23	
22	**R**
23	**R**
24	
25	**R**
26	**R**

R = raw score 5 becomes a 1; raw score 4 becomes a 2; raw score 2 becomes a 4; aw score 1 becomes a 5; raw score 3 remains a 3

Appendix 2

RECOVERY KNOWLEDGE INVENTORY

Please rate the following items on a scale of 1to 5:

1 Strongly Disagree 2 Disagree 3 Not Sure 4 Agree 5 Strongly Agree

1.	The concept of recovery is equally relevant to all phases of treatment.	1	2	3	4	5
2.	People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals.	1	2	3	4	5
3.	All professionals should encourage clients to take risks in the pursuit of recovery.	1	2	3	4	5
4.	Symptom management is the first step towards recovery from mental illness/substance abuse.	1	2	3	4	5
5.	Not everyone is capable of actively participating in the recovery process.	1	2	3	4	5
6.	People with mental illness/substance abuse should not be burdened with the responsibilities of everyday life.	1	2	3	4	5
7.	Recovery in serious mental illness/substance abuse is achieved by following a prescribed set of procedures.	1	2	3	4	5
8.	The pursuit of hobbies and leisure activities is important for recovery.	1	2	3	4	5
9.	It is the responsibility of professionals to protect their clients against possible failures and disappointments.	1	2	3	4	5
10.	Only people who are clinically stable should be involved in making decisions about their care.	1	2	3	4	5
11.	Recovery is not as relevant for those who are actively psychotic or abusing substances.	1	2	3	4	5
12.	Defining who one is, apart from his/her illness/condition, is an essential component of recovery.	1	2	3	4	5
13.	It is often harmful to have too high of expectations for clients.	1	2	3	4	5
14.	There is little that professionals can do to help a person recover if he/she is not ready to accept his/her illness/condition or need for treatment.	1	2	3	4	5
15.	Recovery is characterized by a person making gradual steps forward without major steps back.	1	2	3	4	5
16.	Symptom reduction is an essential component of recovery.	1	2	3	4	5
17.	Expectations and hope for recovery should be adjusted according to the severity of a person's illness/condition.	1	2	3	4	5

18.	The idea of recovery is most relevant for those people who have completed, or are close to completing, active treatment.	1	2	3	4	5
19.	The more a person complies with treatment, the more likely he/she is to recover.	1	2	3	4	5
20.	Other people who have a serious mental illness or are recovering from substance abuse can be as instrumental to a person's recovery as mental health professionals.	1	2	3	4	5

Recovery Knowledge Inventory

Factor	Item Number R (Reversed)	Item Narrative	Theoretical Domains
I	10 R	Only people who are clinically stable should be involved in making decisions about their care.	Self-Determination
I	7 R	Recovery in serious mental illness/substance abuse is achieved by following a prescribed set of procedures.	Individual Process
I	9 R	It is the responsibility of professionals to protect their clients against possible failures and disappointments.	Risk Taking
I	18 R	The idea of recovery is most relevant for those people who have completed, or are close to completing, active treatment.	Recovery-Readiness
I	6 R	People with mental illness/substance abuse should not be burdened with the responsibilities of everyday life.	Citizenship
I	2 R	People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals.	Self-Determination
I	11 R	Recovery is not as relevant for those who are actively psychotic or abusing substances.	Recovery-Readiness
II	15 R	Recovery is characterized by a person making gradual steps forward without major steps back.	Non-linear Process
II	17 R	Expectations and hope for recovery should be adjusted according to the severity of a person's illness/condition.	Hope
II	19 R	The more a person complies with treatment, the more likely he/she is to recover.	Services aren't enough
II	16 R	Symptom reduction is an essential component of recovery.	Managing symptoms
II	14 R	There is little that professionals can do to help a person recover if he/she is not ready to accept his/her illness/condition or need for treatment.	Incorporating Illness
II	4 R	Symptom management is the first step towards recovery from mental illness/substance abuse.	Managing symptoms
III	8	The pursuit of hobbies and leisure activities is important for recovery.	Involvement in Meaningful activities
III	20	Other people who have a serious mental illness or are	Supportive Others

		recovering from substance abuse can be as instrumental to a person's recovery as mental health professionals.	
III	1	The concept of recovery is equally relevant to all phases of treatment.	Recovery-Readiness
III	12	Defining who one is apart from his/her illness/condition, is an essential component of recovery.	Redefining Self
III	3	All professionals should encourage clients to take risks in the pursuit of recovery.	Risk-taking
IV	5 R	Not everyone is capable of actively participating in the recovery process.	Recovery-Readiness
IV	13 R	It is often harmful to have too high of expectations for clients.	Hope

Appendix 3
Vignettes

The Case of Ms. Q

Ms. Q is diagnosed with schizophrenia and cannabis use. She is 25 years old. She lives in a community residence and attends a continuing day treatment program. She participated in a 28 day rehabilitation center. She received glowing reports while in rehabilitation. She began using again on her first day out. A friend saw her smoking a joint. Ms. Q denied substance use in all continuing day treatment program groups she attended. Ms. Q works with a seasoned and skilled social worker, who appears unable to address this issue. Ms. Q's mother lives in Florida and denies her daughter has mental illness. Ms. Q takes a number of psychiatric medications regularly. She has an agreeable personality, but is in denial about her mental illness.

1. On a scale of 1-7, how would you rate Ms. Q's level of functioning? _____
2. Why?
3. What is your strongest concern about Ms. Q's capacity to make her own decisions?
    1. her denial of the illness
    2. her substance abuse
    3. her mother's denial of the illness
    4. her lack of insight about her mental illness
    5. other: (explain)_____
4. What strength most supports Ms. Q's capacity to make her own decisions?
    1. support of psychiatric rehabilitation services
    2. success with detoxification
    3. having a friend
    4. support of a skilled social worker
    5. other: _(explain)_____

The Case of Mr. C

Mr. C is diagnosed with schizophrenia. He is obese and is diagnosed with diabetes, emphysema, and lung cancer. He smokes cigarettes in spite of his pulmonary disease. He has spent the last fifteen years receiving mental health services in continuing day treatment. He does not appear to focus on recovery. Social workers feel he is an example of "learned helplessness," perhaps because of so many years of mental health treatment. He refuses medical intervention and denies his medical conditions. Even though he attends mental health services, he resists his social worker's recommendations.

1. On a scale of 1-7, how would you rate Mr. C's level of functioning? _____
2. Why?
3. What is the strongest argument against Mr. C being recovery ready?
    1. neglect of self care
    2. long history in the mental health system
    3. denial of mental illness
    4. resistant to social worker recommendations

5. other: (explain)_____

4. What is the strongest argument for Mr. C being recovery-ready?
    1. recovery is not a straight path
    2. he is very strong willed
    3. he has a long history in the mental health system
    4. for all people, there is hope
    5. other: (explain) _____

Mr. S

Mr. S is a thirty year old man who participates in continuing day treatment services. Both he and his mother are diagnosed with schizophrenia. He is morbidly obese and weighs approximately 350 pounds. He is intelligent and recognizes that his mental illness interferes with his impulse control and decision making. He considered gastric bypass surgery but was advised against the procedure because he had problems changing his eating behaviors. He denies the gravity of the problem. He uses the hospital emergency room at least once a week because of asthma and his obesity interferes with his breathing. He has sustained many injuries because sometimes he black out. He has fallen twice in the bathtub.

1. On a scale of 1 to 7, how would you rate Mr. S's level of functioning? _____
2. Why?
3. What is the strongest argument against Mr. S being recovery ready
    1. there is a family history of the illness
    2. he has poor impulse control
    3. he is obese
    4. his denial of the gravity of the problem
    5. other(explain)_____
4. What is the strongest argument for Mr. S being recovery-ready?
    1. he possesses insight and acceptance of his illness
    2. he is intelligent
    3. he has reached his bottom
    4. he participates in day treatment services
    5. other: (explain)_____

Ms D

Ms. D can be described as going through revolving door hospitalizations. She feels better as she is re-stabilized on medication. She is diagnosed with bi-polar disorder. She is in her 40s. She is very involved in religious activities which seem to help her functioning until she is encouraged by fellow members of her religious community to stop taking medications, and she stops taking medications. At this point she becomes aggressive and sexually pre-occupied. In one year she had 15 hospitalizations. Her program sought an AOT which was granted, however, they also sought long term hospitalization which was denied.

1. On a scale of 1 to 7, how would you rate Ms. D's level of functioning? _____
2. Why?

3. What is the strongest argument against her ability to make decisions for herself?
    1. she has not learned how to stabilize self on medications
    2. her support system does not support medication
    3. history of aggression and sexual pre-occupation
    4. the system will not provide her with the long term treatment she needs
    5. other: (explain)_____

4. What is the strongest argument for her being able to make decisions for herself?
    1. she has a strong support system in her religious community
    2. she has an AOT
    3. her diagnosis is the less severe of the severe and persistent mental illnesses
    4. she should be entitled to take the same risks and make the same mistakes as other people
    5. Other: (explain) _____

Ms. Z

Ms. Z suffers with major depressive disorder. She is also HIV positive and suffers with medical complications. She graduated from a community residence to a scattered site apartment with a roommate. For many months she functioned very well. She maintained the apartment, maintained a budget and maintained her mental health. She had some difficulty getting along with her roommate and this situation escalated. She became symptomatic and ultimately had a complete psychiatric break. She is back in a community residence. She is actively involved in the community residence life and is a consumer advocate at her day treatment program.

1. On a scale of 1-7, how would you rate Ms. Z's level of functioning? _____
2. Why?
3. What is the strongest argument for Ms. Z to be able to make decisions for herself?
    1. she has a history of functioning at a high level
    2. she evidences an ability to bounce back from setbacks
    3. she has been able to engage in meaningful activities that give purpose to her life
    4. she is a leader within her community
    5. Other: (explain)_____

4. What is the strongest argument against Ms. Z being able to make decisions for herself?
    1. she has numerous medical and psychological problems
    2. she was unable to sustain success
    3. she has difficulty getting along with others
    4. she needs to partake in low stress activities
    5. other: (explain)_____

Appendix 4: Informational Questions

1. How many years have you been working with clients with mental illness? Please circle your response.
    1. less than one year
    2. one to five years
    3. six to ten years
    4. ten to twenty years
    5. over twenty years
2. Circle all the credentials you hold.
    1. MSW
    2. Post masters certificate
    3. PhD or DSW
    4. Post doctoral training certificate
3. In what type of community are you employed?
    1. urban setting
    2. suburban setting
    3. rural setting
4. In what type of setting do you work? Circle all that apply.
    1. in-patient setting
    2. day hospital setting
    3. continuing day treatment program setting
    4. clinic setting
    5. private practice setting
    6. other , please specify?
5. Do you have a family member or close friend who suffers with mental illness?
    1. yes
    2. no
6. What theory or frame of reference most guides your practice?
    1. Biological
    2. psycho-dynamic
    3. cognitive behavioral
    4. behavioral
    5. family systems
    6. socio-cultural
    7. other? Please specify
7. Does the culture of your agency embrace a recovery paradigm?
    1. yes
    2. no

Appendix 5 Recruitment Letter

Recruitment Letter

Letter of Introduction

Dear NASW Member:

You are invited to participate in a survey that I will be conducting as a doctoral candidate in the PhD Program in Social Welfare at the CUNY Graduate Center. The study is about the attitudes of social workers working with people with serious mental illness about the recovery movement and psychiatric rehabilitation You are asked to participate in this study if you have at least an MSW degree and work with people with mental illness. If you decide to participate in this study, you will be asked to complete a paper and pencil survey. It includes questions about your experiences, attitudes, opinions about working with mentally ill people and their recovery and treatment The survey should take about 30 minutes to complete, and I anticipate that 200 mental health workers from across New York State will participate in the study.

There are no direct benefits to you for participating and no known risks to your participation. But your participation may contribute to knowledge about social workers and the recovery movement and how they make decisions about caring for people with mental illness. If you decide to complete the survey, you will be eligible to enter a lottery for a $100 American Express gift card. There is a card enclosed where you can indicate whether or not you want to enter the lottery, which will involve providing your contact information.

Your participation in this survey is entirely voluntary, and you may skip any question you do not want to answer. If you do not want to complete the questionnaire, simply ignore it. If you agree to participate, please mail the completed survey back in the enclosed stamped self addressed envelope. By completing and returning this survey you are agreeing to participate in the study.

The survey is anonymous. None of the questions will identify you as an individual. All responses will be reported in the aggregate and the results of the study will be used for my doctoral dissertation, scholarly presentations, or articles for publication.

You may contact me, Debra-Kram Fernandez at debbishouse@hotmail.com if you have any questions about the study. If you have questions before you make your decision, please contact me. I will be sending the survey with a self addressed stamped return envelope in the next week.

Thank you for your consideration.

Sincerely,

Debra-Kram-Fernandez
PhD Candidate, PhD Program in Social Welfare
Hunter College School of Social Work and the
CUNY Graduate Center

Appendix 6 Invitation to Participate in Study and Consent Form

Consent Form

Dear NASW Member:

You are invited to participate in a survey conducted Debra Kram-Fernandez, a doctoral candidate in the PhD Program in Social Welfare at the CUNY Graduate Center. The study is about the attitudes of social workers working with people with serious mental illness about the recovery movement and psychiatric rehabilitation You are asked to participate in this study if you have at least an MSW degree and work with people with mental illness. If you decide to participate in this study, you will be asked to complete a paper and pencil survey. It includes questions about your experiences, attitudes, opinions about working with mentally ill people and their recovery and treatment The survey should take about 30 minutes to complete, and I anticipate that 200 mental health workers from across New York State will participate in the study.

There are no direct benefits to you for participating and no known risks to your participation. But your participation may contribute to knowledge about social workers and the recovery movement and how they make decisions about caring for people with mental illness. If you decide to complete the survey, you will be eligible to enter a lottery for a $100 American Express gift card. There is a card enclosed where you can indicate whether or not you want to enter the lottery, which will involve providing you contact information.

Your participation in this survey is entirely voluntary, and you may skip any question you do not want to answer. If you do not want to complete the questionnaire, simply ignore it. If you agree to participate, please mail the completed survey back in the enclosed stamped self addressed envelope. You may skip any questions you do not want to answer. By completing and returning this survey you are agreeing to participate in the study.

The survey is anonymous. None of the questions will identify you as an individual. All responses will be reported in the aggregate and the results of the study will be used for Debra Kram-Fernandez's doctoral dissertation, scholarly presentations, or articles for publication.

You may Debra-Kram Fernandez at debbishouse@hotmail.com if you have any questions about the study. If you have questions about your rights as a subject or feel you have experienced a research-related injury, you should contact the Office of Research Administration at (212) 650-3053.

Thank you for your consideration.

Sincerely,

Debra-Kram-Fernandez
PhD Candidate, PhD Program in Social Welfare
Hunter College School of Social Work and the
CUNY Graduate Center

Appendix 7

Web Links

http://www.naswnys.org/

http://www.naswnyc.org/

http://partnersforrecovery.samhsa.gov/recovery.html

www.promtoeacceptance.samhsa.gov/CMHR/default.aspx

mentalhealth.samhsa.gov/

http://www.nami.org

Appendix 8

Completion Card to Enter Lottery

I have completed the survey. Please alert me as to whether I won the lottery.

Name:

Address:

Telephone number:

Appendix 9

Permissions

From: luis.bedregal@yale.edu
Subject: Recovery Knowledge Inventory
To: debbikramfernandez@hotmail.com

Dear Debra:
You do have our permission to use the RKI. I am attaching two documents: One is the 20-item RKI form and the other document contains scoring of items, empirically derived dimensions, item narrative, and theoretically derived domains.

The way to score this instrument is to get means for each domain. Then, judge each factor's mean according to Likert scale (means of 4 and 5 are good and excellent, a mean of three is okay, and means of one and two are not so good).

Do not forget to change scores on items that are reversed (i.e., a score of one will be a five, a two will be a four, a three will remain the same, a four will be a two, and a score of five will be a one).

If you have any more questions, please do not hesitate to contact me. Good luck on your work and I'll greatly appreciate if you share your results with us. Regards,
Luis

Quoting debra kram-fernandez <debbikramfernandez@hotmail.com:

Hello Dr. Bedregal, Dr. O'connell and Dr. Davidson,

I am a doctoral student in social welfare at the City University of New York Graduate Center in New York City, and I am planning to focus my doctoral dissertation on mental health practitioners' embrace of recovery oriented treatment. I came across the RKI while working on my literature review and I wonder if I can use it in my research.

Thank you very much for your time and consideration.

Sincerely,

Debbi Kram-Fernandez

Date: Sat, 1 Nov 2008 13:39:30 -0400
From: ecasper@nyc.rr.com
To: debbikramfernandez@hotmail.com

Subject: RE: The Psychiatric Rehabilitation Beliefs, Goals and Practices Scale

Sorry for the delay in replying, Debbie, but I have been traveling. There is no charge for students and other researchers to use the PRBGP. There is a use fee for mental health institutions so please do not share the scale with them if they are participating in your research. I have attached the PRBGP and the scoring key. Both are in MS Word format. Be alert, the PRBGP prints onto two legal-size pages. When you duplicate the scale, I suggest that you create one, double-sided, legal-size page. This will eliminate the need for multiple pages and reduces the risk of pages separating and losing data. If you have any questions, email me. Good luck with your research. If possible let me know what you find. EdC

---- debra kram-fernandez <debbikramfernandez@hotmail.comwrote:

Hi Dr. Casper,

I hope I can still reach you at this e-mail address. I am writing to request permission to use the PRBGPS as part of my doctoral dissertation. I am a Level III student at the CUNY Graduate Center and I am very interested in looking at mental health practitioners embrace of the recovery paradigm. You recommeded four articles to me three years ago. I have read them and so has my advisor, and the scale appears to be well suited for my research question. I hope to hear from you soon.

Debbi Kram-Fernandez

of course, please do. luis can give you any assistance you might need with coding, etc.

debra kram-fernandez wrote:
Hello Dr. Bedregal, Dr. O'connell and Dr. Davidson,

I am a doctoral student in social welfare at the City University of New York Graduate Center in New York City, and I am planning to focus my doctoral dissertation on mental health practitioners' embrace of recovery oriented treatment. I came across the RKI while working on my literature review and I wonder if I can use it in my research.

Thank you very much for your time and consideration.

Sincerely,
Debbi Kram-Fernandez

--
Larry Davidson, Ph.D.
Professor of Psychiatry and Director

Program for Recovery and Community Health
School of Medicine and Institution for Social and Policy Studies
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