Thinking Through Recovery: Resolving Ethical Challenges and Promoting Social Work Values in Mental Health Services

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Abstract

The President's New Freedom Commission has endorsed recovery as a model for mental health system transformation. With its emphasis on promoting autonomy, client choice, and self-directed care, recovery is consistent with social work values. This article argues that recovery represents a significant step forward in our understanding of mental health services, but also raises important ethical issues regarding competence and safety. The authors discuss how, by utilizing interventions such as psychiatric advance directives, shared decision-making, wellness recovery action plans, and person-centered planning, social workers can promote client autonomy and both recovery and social work values.

Keywords: recovery movement; shared decision-making; psychiatric advance directives; autonomy; ethics

1. Introduction

Since the inclusion of recovery as the cornerstone of mental health services transformation in the New Freedom Commission report, the goal of increasing the implementation of recovery-based services has drawn both boosters and critics. Satel and Zdanowicz (2003) have criticized the New Freedom Commission report as failing to address the needs of the most severely ill, because of its emphasis on recovery-oriented services; they argue that for persons with severe mental illness, the ability to recover is out of reach. This concern is mirrored by mental health professionals who believe that handing over greater decision-making to patients invites poorer treatment compliance and increased rates of hospitalization or incarceration, as well as potential liability (Anthony, 1993; Davidson, O'Connell, Tondora, Styron, & Kangas, 2006). On the other hand, recovery proponents argue that this treatment philosophy helps build client capacity,

and corrects the abuses inherent in traditional paternalistic treatment models (Jacobson & Greeley, 2001). Advocates further suggest that recovery promotes greater client ownership, and thus results in better treatment outcomes (Carpenter, 2002; Bullock, Ensing, Alloy, & Weddle, 2000).

Recovery is consonant with social work values, and therefore social workers should be particularly interested in understanding this orientation toward treatment. The National Association of Social Workers (NASW) (2008) Code of Ethics states that "social workers promote clients' socially responsible self-determination," and that "social workers seek to enhance clients' capacity and opportunity to change and to address their own needs" (Ethical principles, para. 4). There are many challenges to mental health systems' transformation to a recovery orientation, not the least of which is the ever-present problem of inadequate resources for programming and services. Even with limitless resources, promoting recovery would still require social workers to engage with essential questions regarding client competency, safety, civil liability, and the needs of family caregivers.

This article discusses the features of recovery-oriented services, the origins of recovery ideas, and most importantly, why recovery is ethically significant. Most clients—even those with severe mental illness—can engage in recovery at some level, and contribute to treatment planning. With that in mind, this paper also details several strategies for incorporating a recovery orientation into mental health services.

2. Recovery: What It Means and Why It Matters to Social Workers

Internationally, psychiatric recovery has become a guiding principle for the reform of mental health care (Amering & Schmolke 2009; Plat, Sabetti, & Bloom, 2010; Slade, Amering, & Oades, 2008). This approach to reform is now embraced by federal agencies, state mental health authorities, and local mental health jurisdictions (Davidson, Tondora, O'Connell, et al., 2007; Goldberg & Resnick, 2010). The recovery movement and recovery-oriented services present a unique challenge to clinicians, researchers, and behavioral health administrators. The term recovery is often ill-defined or misused, resulting in confusion about what recovery advocates are really working toward, and frequently in the summary dismissal of recovery ideals.

It has been a number of years since the New Freedom Commission issued its report, but the challenges associated with implementing recovery-oriented services remain current. For instance, Brown and colleagues (2010) found great variability in the degree to which state agencies in California had incorporated recovery-oriented services. The variability was a function of characteristics of both agencies and individual service providers. Recovery calls for systems transformation, a process that has continued to unfold in the years since the Commission report. Encouragingly, the Department of Veterans Affairs (2010) has recently cited recovery as a guiding principle in the provision of mental health services for American servicemen and women.

2.1 The background of recovery

Recovery is not in fact a new development, but rather the result of the evolution of mental health policy and treatment philosophy that has occurred over the decades since deinstitutionalization. Mental health recovery shares some commonalities with the self-help movement in substance abuse treatment; the concept of being in a state of recovery, in terms of either mental health or substance abuse, assumes a lifelong course of illness and a process of overcoming its challenges. While mental health and substance abuse treatments share this core belief, they are distinctly different movements with different origins (Gagne, White, & Anthony, 2007).

As a result of a critical juncture of political, social, medical, and economic factors, mental health policy changed course in the 1950s with the movement toward deinstitutionalization and

community-based treatment for persons with severe mental illness. Federal policy and financial support led first to the establishment and then the expansion of community mental health centers throughout the United States (Anthony, 1993; Grob, 1992). The deinstitutionalization of persons with mental illness was, in part, a response to growing concerns over patient rights and psychiatric paternalism, as well as the decaying conditions of the states' psychiatric institutions. As patients left the hospitals and attempted to reintegrate into the community, it became clear that the limited scope of the medical model of mental health treatment was failing to meet the range of psychosocial needs of mental health consumers. While clients were institutionalized, their basic needs—clothing, nutrition, shelter, and treatment—were met by the institutional structure. Although community mental health centers provided medication and therapy, other critical services, such as housing, employment supports, and nutritional supports, were largely outside these centers' purview. In addition, clients began to assert greater control over treatment decisions; prominent legal cases such as *Lessard v. Schmidt* (1972) and *O'Connor v. Donaldson* (1975) reinforced the individual liberties of persons with mental illness, and treatment in the least restrictive environment. From the intersection of patient rights, the recognition of service failures, critiques of the traditional medical model in mental health, and the growing dominance of autonomy in medical ethics, the mental health consumers' movement emerged. This movement has played a critical part in the history of the recovery orientation.

The mental health consumer movement started in the 1970s as a civil rights movement, which was often referred to as the survivors' or ex-patient movement, as the term *consumer* implies that service users have a choice of services that meet their needs. This movement was a radical antipsychiatry ideology opposing the injustices and oppression that many ex-patients had encountered in psychiatric hospitals (Corrigan, Mueser, Bond, Drake, & Solomon, 2008; USDHHS, 1999). These service users saw themselves as "having been rejected by society and robbed of power and control over their lives," and "began to advocate for self-determination and basic rights" (USDHHS, 1999, p. 93). Consumers became a strong voice in mental health advocacy and continue today to have an influential voice in the design and reform of mental health policy and services, although they are now far more moderate in their views. Consequently, these advocates argued that changing mental health policy was about basic human rights and empowerment. Similarly, the psychiatric rehabilitation approach, started in the 1940s by a group of ex-patients and professionals, addressed the inadequacy of the medical model by focusing psychiatric treatment goals on all domains of life (Corrigan, et al., 2008). The field of psychiatric rehabilitation spoke of consumer choice, self-determination, person-centered planning, and community role outcomes. The trend toward recovery-oriented services is a merging of community-based psychiatric rehabilitation programs that proffer a holistic approach to treatment, and the ethical and civil concerns raised by the consumers' movement. The recovery orientation is a response to consumer concerns about disrespect, coercive practices, paternalism, and a lack of partnership in their own care.

2.2 Defining recovery: Philosophy and process

Recovery consists of an approach to treatment that is a collaboration between the consumer and the service provider. Anthony (1991) defines recovery as "the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability" (p.13). It is about reshaping or reconceptualizing one's life to take account of mental illness, while emphasizing the fact that the possibility for a rich, rewarding, and meaningful existence is still within reach, despite persistent mental illness. Recovery is client-centered and

client-directed, and the client decides how her recovery—and success in reaching her goals—ought to be defined. The President's New Freedom Commission (2003) states that recovery involves the consumer deciding who will be part of a treatment team and sharing in the decision-making regarding treatment plans. The recovery movement is based on "democratic principles of self-determination, as well as scientific issues concerning the possibility of recovery and to encourage the client to identify sources of support," that seeks to "identify strengths, as well as vulnerabilities" and "to work in a collaborative way with the patient" (Mulligan, 2003, p. 11).

Jacobson and Greenley (2001) argue that recovery is defined by the "internal and external conditions [that] produce the process called recovery" (p. 482). These internal conditions include hope, healing, empowerment, and connection; the external conditions include human rights, a culture of healing, and recovery-oriented services. Hope is the belief that recovery from severe mental illness is possible, while healing is the process of "recovering the self" by "reconceptualizing illness as only part of the self" rather than the defining feature of the self, and also uncovering the means of controlling symptoms. Empowerment entails the recovery of a sense of control by assuming a greater role in one's treatment, while connection entails finding "roles to play in the world" with the understanding that recovery is a "social process" (Jacobson & Greenley, 2001). External conditions are best understood as a supportive environment that recognizes the value of human rights by seeking a more equitable distribution of power between consumers and providers. Pursuing potential opportunities for housing, employment, and education is part of being in the process of recovery (Jacobson & Greenley, 2001). Onken and colleagues (2007) recognize recovery as not only a philosophy of patient agency and self-determination, but also a "nonlinear process that involves making progress, losing ground, and pressing forward again" (p. 10). Furthermore, recovery is the "process of gaining mastery over the illness," which may mean the alleviation not just of symptoms, but of social marginalization as well (p. 10).

Recovery, then, can be thought of in two distinct yet related ways. It is a model for understanding the process by which an individual copes with a mental illness and comprehends the often nonlinear course of a mental illness. Secondly, it can be understood as a treatment philosophy and ethical orientation toward mental health services. Those who perceive the term "recovery" as unachievable are defining it strictly as an outcome (as in "I have recovered.") rather than as a process and philosophy (as in "I am in recovery."). The point is not to minimize outcomes, but rather to show that instituting recovery in clinical practice requires that clinicians participate in the process of reconceptualizing mental illness and its treatment. The development of recovery as a treatment philosophy does address previous ethical conflicts in behavioral health such as coercive treatments and excessive paternalism, but it also raises new ethical challenges.

3. The Ethical Challenges of Recovery

Wolpe (1998) has noted that within the medical and bioethics community, the principle of autonomy or respect for persons has assumed a "hallowed place" in American medical values. While this may seem less controversial in many medical fields, it is a dilemma in behavioral health, where the decisional capacity of individuals may be in question. We proceed by looking briefly at the evolution of autonomy in medical ethics, which will lay the foundation for a discussion of specific ethical challenges that are raised by the recovery movement in the mental health arena.

3.1 Paternalism and autonomy

In his treatise on medical ethics published in 1803, Thomas Percival argued that "nonmaleficence and beneficence fix the physician's primary obligations and triumph over

the patient's preferences and decision-making rights in circumstances of serious conflict" (Beauchamp & Childress, 2009, p. 35). Percival's work became the paradigm for the American Medical Association's first code of ethics, and his views on beneficence are deeply ingrained into medical education and practice. While this paternalistic model held for the medical profession in general for generations of physicians and patients, it was more pronounced when applied to mental health clients, who were viewed literally as childlike, lacking the capacity for rational choice and full moral agency. Thus, medical paternalism had serious implications for the ability of persons with mental illness to make treatment choices. Those who resisted medication or other mental health treatments were simply considered recalcitrant; resistance is still often viewed as just another symptom of the person's illness. Consequently, a power differential emerged between clinician and client, with the clinician acting in many cases as the surrogate decision maker, thus reducing the client to a passive recipient of care.

By the second half of the 20th century, controversies in medicine and research allowed for the entry of nonclinicians into the ethical debate. In mental health, scathing exposés by Deutsch (1948) and Maisel (1946), sociological critiques by Goffman (1961), and the burgeoning "antipsychiatry" movement led by Szasz (1960) focused attention on abuses of the individual liberties of psychiatric patients. While the antipsychiatry movement may have been too radical, it did nevertheless raise important critiques of how those with mental illness were disempowered. By the early 1970s, the principle of autonomy had become central to the NASW Code of Ethics. Autonomy, sometimes referred to as "respect for persons," emerged from the belief that all persons must be understood as an "end in themselves" with goals, dreams, aspirations, and potential. Thus, recovery supports autonomy by recognizing it as both an intrinsic and an instrumental good: Promoting client autonomy typically results in better treatment outcomes (Stewart, 1995; Kiesler & Auerbach, 2003; Mead & Bower, 2000). Furthermore, it is also a good in itself.

Autonomy and respect for persons has supplanted beneficence as the dominant value in medical ethics, but it poses a conceptual challenge in the field of mental health. Ethics rests upon assumptions about agency, which is the ability of persons to deliberate and act with intention. As such, behavioral health in general and recovery more specifically presents a unique challenge in that the agency of persons with severe mental illness may at times be questioned. The moral challenge that lies before us then is to maximize autonomy, while simultaneously recognizing that there are occasions when autonomy may need to be abridged, albeit temporarily. We proceed by highlighting specific challenges to this balancing act, and conclude with intervention strategies that may help to maintain individual sovereignty even when there are questions of client competence.

3.2 Competency and capacity

Competence can be thought of as the possession of certain decisional capabilities. These decisions can be diverse, such as financial decisions, ability to enter into contracts, or the ability to make medical decisions. A person may be competent in some areas, such as making medical choices or deciding to participate in research, while being incompetent in other areas, such as managing finances; furthermore, competence may vary over time, especially when linked with the natural course of a mental disorder (Appelbaum & Grisso, 1995). Informed consent, or the ability to weigh risks and benefits of pursuing or declining specific medical intervention, is the cornerstone of contemporary medical ethics, and it is contingent on the competence of the client. Medical paternalism has often been justified by a perceived lack of competence among psychiatric patients.

Promoting client-directed care requires a careful assessment of client competency by

clinicians, along with continuous monitoring as competence varies over time. It is important to note that competency is not merely the ability to deliberate; in order to be competent, a client must have all of the relevant information needed to make a choice. The competence of individuals is rarely questioned when they voluntarily submit to treatment; rather, it is often seen as an issue when treatment is refused, regardless of the reasons. To be sure, it is easier and more expedient for a clinician to make assumptions about the competency of a client based on client behaviors, and to act accordingly by seeing compliance as a sign of competence, and recalcitrance as a sign of diminished decisional ability. Because competence cannot be reduced to such simple rules, it challenges the decision-making and risk-assessment skills of practitioners who are instituting recovery-oriented services which are based, in part, on the decisional capacity of the client. To be clear, we are not talking about the legal definition of competency—that is a decision made by courts—but rather the ongoing assessment made by practitioners who must decide the degree to which they will support client choice. While degree of competency may vary over time, the vast majority of clients can engage in their recovery planning the majority of the time, particularly when employing strategies to be discussed later.

3.3 Ethico-legal challenges

A second major challenge in instituting recovery-oriented services involves the very real conflict faced by clinicians as they try to finely balance client autonomy against the responsibility of a clinician to protect third parties and prevent self-harm. It is often the case that persons with severe mental illness are brought to the attention of clinicians, because their mental illness has resulted in either suicidal ideation, poor self-care, or in rare cases, violent threats or violence against others. In such situations, the clinician is charged with providing care and ensuring safety for all. Whether to err on the side of client autonomy or to err on the side of paternalism is a moral question. However, the moral question is informed by legal precedent such as the *Tarasoff v. Regents of the University of California* (1976) decision, a case in which a clinician was found liable in civil court for a murder committed by his client. The fear that one will be held transitively responsible for the actions of one's client may tip the balance against autonomy.

There has been some pushback against efforts to place greater treatment choice in the hands of clients. This counterorganizing force is based largely on fears that greater client control will result in larger numbers of people opting out of pharmaceutical and behavioral health treatments, resulting in a greater occurrence of adverse events such as homelessness, substance abuse, suicide, and violence toward others. Torrey (2002) has been a critic of mental health consumer advocates, arguing that their desire to limit involuntary treatment prevents physicians from properly following their duty to protect both the client and the community. These arguments are a restatement of concerns of an earlier era raised in the wake of *O'Connor v. Donaldson*; former Winnebago State Hospital superintendent Darold Treffert (1973) famously argued that the greater assertion of client autonomy over medical authority has resulted in clients—often homeless and unmedicated—"dying with their rights on" (p. 1041).

3.4 Families' concerns with recovery

Lastly, family and significant-person caregivers have expressed concerns about the impact of recovery models on mental health services. Family members often act as caregivers for persons with severe mental illness (Lefley, 1996). Accordingly, family caregivers are sometimes the targets of abusive behaviors—emotional, verbal, or physical—by relatives with mental illness (Estroff & Zimmer, 1994; Estroff, Zimmer, Lachicotte, & Benoit, 1994; Solomon, Cavanaugh, & Gelles, 2005). Though relatively uncommon, such abusive situations

are exacerbated by inadequate services and poor treatment compliance. Thus, while some groups have endorsed recovery-based services as building client capacities and responsibility, some family caregivers have expressed concerns that self-directed care results in poorer treatment compliance and diminished participation in treatment programs.

4. Instituting Recovery

While paternalism is often undesirable, we cannot simply replace it with an equally radical form of autonomy. While we strive toward overall client autonomy and choice, there may emerge times when clinical paternalism is appropriate. However, there are steps that may be taken by both clients and clinicians to mitigate the potential constraints on autonomy that may intermittently emerge.

4.1 Promoting autonomy

Promoting client autonomy while still attending to issues of competence, safety, and liability requires that clients and providers develop long-term plans that address the periodic exacerbations that are part of the natural course of mental illness. Utilizing shared decision-making, advance directives, wellness recovery action plans and person-centered planning are critical elements for a recovery orientation to social work practice.

A major concern of clinicians and family caregivers is that given greater treatment choices, persons with mental illness will opt out of taking medications. However, consumer advocates and researchers such as Deegan and Drake (2006) argue that outcomes such as "compliance" are relics of medical paternalism. Instead, they promote the use of shared decision-making (SDM) as a way of empowering clients and mitigating some of the ethical concerns raised by recovery critics.

Rather than seeing treatment as a binary choice (compliance versus noncompliance), the process of shared decision-making views ongoing treatment choices as an active and complex decision-making process. Proponents of recovery and shared decision-making argue that there is ample evidence to show that adoption of medications or other treatments is influenced by many factors, and is not merely a sign of recalcitrance. Evidence suggests that factors such as side effects, treatment efficacy, and social stigma influence decisions to use medications; some clients may opt to take medication only to control certain intermittent symptoms (Donovan & Blake 1992). Deegan and Drake (2006) propose that clinicians must work closely with clients to arrive at a "mutually acceptable plan for moving forward" and that "the practitioner's role is not to ensure compliance but rather to help the client to use the medications and other coping strategies, optimally in the process of learning to manage his illness" (p. 1636).

It is important that both parties recognize their respective expertise: The social worker knows the literature and has amassed clinical experience, while the client understands his individual preferences and subjective experience of illness. Thus, shared decision-making is not simply deferring to whatever the client wants, but rather is a combining of client experience and needs with clinical expertise and sound counsel to work through treatment issues; counter arguments that recovery is a euphemism for "do whatever you want" are unfounded. Recognizing the importance of shared decision-making in achieving good clinical outcomes, the Substance Abuse and Mental Health Services Administration (2010) serves, in part, as a clearinghouse for interactive tools to aid clinicians and clients in initiating the shared decision-making process. These tools range from general decision-making about treatment options and employment to specific decision-making aids directed at the use of antipsychotic medications. While SDM has existed in medical practice for decades, its application in the field of behavioral health is scant, and research on its application is minimal (Duncan, Best, & Hagan, 2010). Due to the particular ethical orientation of social work, however, and its focus on client autonomy and self-determination, SDM ought

to receive greater emphasis as a critical service strategy for forwarding the ethics of social work and the goals of recovery. Drake and Deegan (2009) have declared that it is "time to take the moral high road" and promote SDM since "autonomous adults have the right to determine what happens to their bodies and minds." To them, utilizing SDM is an "ethical imperative" (p. 1007).

Shared decision-making is dependent on at least some degree of client competence. However, there are times during the course of an illness when competency and decisional capacity may be compromised, when it may be incumbent on the clinician or family members to substitute their judgment, and act in the client's best interests. Ensuring that the client's wishes are honored and incorporated during these times of highly symptomatic behavior can be achieved through the use of advance directives. Similar in some ways to living wills, psychiatric advance directives (PADs) are used to document the treatment preferences of persons with mental illness so that their wishes can be known and followed at times of psychiatric crisis. These directives are created when the client is non-symptomatic (or less symptomatic) and therefore is competent to make sound treatment choices. Psychiatric advance directives document preferences in regard to medications, the use of restraints, hospitalization, and the use of electroconvulsive therapy (Appelbaum 1991; Srebnik & Russo, 2008). In addition, clients may appoint surrogate decision makers, rather than face the appointment of a guardian through a court process. Research by Srebnik and Russo indicates that when the client takes active steps to appoint a surrogate (rather than rely upon court intervention), advance directives are more likely to be accessed by a treatment team. Despite the potential that PADs hold for promoting recovery-based services, research on their implementation and impact remains scant (Van Dorn, Scheyett, Swanson, & Swartz, 2010).

Similar to PADs, wellness recovery action plans (WRAPs) are a crisis planning tool. Unlike PADs, which are adapted from medical advance directives, the WRAP has emerged from consumers themselves, and they are often created through the collaboration of the client and a peer specialist. Additionally, crisis intervention plans are merely a part of a WRAP, which is focused on an overall, client-directed strategy for managing severe mental illness (Cook et al., 2010). Roberts and Wolfson (2004) promote the WRAP as a recovery-oriented intervention that helps individuals take control of their lives. This is accomplished by collaborating with people to identify behaviors associated with symptom reduction and incorporating them into a formal written plan. This planning tool identifies triggers, steps to avoid them, and crisis planning. Recently, person-centered care and planning has also been promoted as a means of documenting agreements and decisions between the client and his or her treatment team, friends, and family. This document is strengths-based and focuses on recovery goals and assets available to reach those goals (Adams & Grieder, 2011). Unlike the usual treatment planning process of the social worker developing the planning often in the absence of the client, a person-centered plan is jointly developed.

5. Conclusion

Recovery as a philosophy presents a significant critique of clinical ethics and insists on making the client a partner in treatment decisions, thereby reducing the traditional power differential that exists between client and provider. Recovery as an ongoing process is an important way of conceptualizing the course of mental illness and its treatment. As a treatment philosophy that values autonomy and promotes greater client participation in making treatment choices, recovery reflects long-established social work values. Given the consistency of recovery with the tenets of the social work profession, social workers, along with consumers, should assume leadership in the promotion of recovery-oriented practice. They should serve as role models by understanding what recovery is, and by using these recovery-oriented practice strategies preemptively as a

matter of course, thus promoting client autonomy, choice, and self-directed care and avoiding the need to resort to power struggles with clients over paternalistic decisions. Working from a recovery orientation ensures that social workers are practicing from the profession's value base.

References

Adams, N., & Grieder, D. (2011, April 11). Person-centered care and planning. *SAMHSA/CMHS Consumer Affairs E-News.* Retrieved from https://list.nih.gov/cgi-bin/wa.exe?A2=ind1104&L=CMHS_ADCA_ENEWS&F=&S=&P=3194

Anthony, W. (1991). Recovery from mental illness: The new vision of services researchers. *Innovations and Research, 1*(1), 13–14.

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psycho-social Rehabilitation Journal, 16*(4), 11–23.

Appelbaum, P. (1991). Advance directives for psychiatric treatment. *Hospital and Community Psychiatry, 42*(10), 983–984.

Appelbaum, P., & Grisso, T. (1995). The MacArthur treatment competence study. I: Mental illness and competence to consent to treatment. *Law and Human Behavior, 19*(2), 105–126.

Amering, M., & Schmolke, M., (2009). *Recovery in mental health: Reshaping scientific and clinical responsibilities.* Chichester, UK: John Wiley & Sons, Ltd.

Beauchamp, T. L., & Childress, J. F. (2009). *Principles of Biomedical Ethics* (6th ed.). New York: Oxford University Press.

Brown, T., Mohoney, C., Adams, N., Felton, M., & Pareja, C. (2010). What predicts recovery orientation in county departments of mental health? A pilot study. *Administration and Policy in Mental Health, 37*(5), 388–398.

Bullock, W., Ensing, D., Alloy, V., & Weddle, C. (2000). Leadership education: Evaluation of a program to promote recovery in persons with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 24*(1), 3–11.

Carpenter, J. (2002). Mental health recovery paradigm: Implications for social work. *Health and Social Work, (27)*2, 86–94.

Cook, J., Copeland, M., Corey, L., Buffington, E., Jonikas, J., Curtis, L., Grey, D., & Nichols, W. (2010). Developing the evidence base for peer-led services: Changes among participants following Wellness Recovery Action Planning (WRAP) education in two statewide initiatives. *Psychiatric Rehabilitation Journal, 34*(2), 113–120.

Corrigan, P., Mueser, K., Bond, G., Drake, R., & Solomon, P. (2008). *Principles and practice of psychiatric rehabilitation: An empirical approach.* New York: The Guilford Press.

Davidson, L., O'Connell, M., Tandora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services, 57*(5), 640–645.

Davidson, L., Tondora, M., O'Connell, M., Kirk, T., Rockholz, P., & Evans, A. (2007). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal*, *31*(1), 223–231.

Deegan, P. & Drake, R. (2006). Shared decision making and medication management in the recovery process. *Psychiatric Services, 57*(11), 1636–1639.

Department of Veterans Affairs. (2010). Mental health recovery: A journey of healing and transformation. Retrieved from http://www.mentalhealth.va.gov/featurearticle_may2010v2.asp

Deutsch, A. (1948). *The Shame of the States*. New York: Harcourt, Brace, and Company.

Donovan, J. & Blake, D. (1992). Patient non-compliance: Deviance or reasoned decision-making? *Social Science and Medicine, 34*(5), 507–513.

Drake, R., & Deegan, P. (2009). Shared decision making is an ethical imperative. *Psychiatric Services*, *60*(8), 1007.

Duncan, E., Best, C., & Hagen, S. (2010). Shared decision making interventions for people with mental health conditions. *Cochrane Database of Systematic Reviews 2010, Issue 1.* Art. No.: CD007297. DOI: 2010.1002/14651858. CD007297.pub2.

Estroff, S., & Zimmer, C. (1994). Social networks, social support and violence among persons with severe, persistent, mental illness. In J. Monahan & H. Steadman (Eds.), *Violence and mental disorder* (pp. 259–295). Chicago: University of Chicago Press.

Estroff, S., Zimmer, C., Lachicotte, W., & Benoit, J. (1994). The influence of social networks and social support on violence by persons with serious mental illness. *Hospital and Community Psychiatry, 45*(7), 669–679.

Gagne, C., White, W., & Anthony, W. (2007). Recovery: A common vision for the field of mental health and addictions. *Psychiatric Rehabilitation Journal, 31*(1), 32–37.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. New York: Anchor Books.

Goldberg, R. & Resnick, S. (2010). U.S. Department of Veterans Affairs (VA) efforts to promote psychosocial rehabilitation and recovery. *Psychiatric Rehabilitation Journal, 33*(4), 255–258.

Grob, G. (1992). Mental health policy in America: Myths and realities. *Health Affairs, 11*(3), 7–21.

Jacobson, N. & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services, 52*(4), 482–485.

Kiesler, D., & Auerbach, S. (2003). Integrating measurement of control and affiliation in studies of physician-patient interaction: The interpersonal circumplex. *Social Science & Medicine, 57*(9), 1707–1722.

Lefley, H. (1996). *Family caregiving in mental illness*. Thousand Oaks, CA: Sage.

Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972).

Maisel, A. (1946, May 6). Bedlam 1946: Most U.S. mental hospitals are a shame and a disgrace. *Life, 20*(18), 102–118.

Mead, N., & Bower, P. (2000). Patient-centeredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine, 51*(7), 1087–1110.

Mulligan, K. (2003, January). Recovery movement gains influence in mental health programs. *Psychiatric News*, *38*(1), 10.

National Association of Social Workers. (approved 1996, revised 2008). *Code of Ethics of the National Association of Social Workers.* Retrieved from http://www.naswdc.org/pubs/code/code.asp.

New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America. Final report*. DHHS Pub. No. SMA-03-3832. Rockville, MD.

O'Connor v. Donaldson, 422 U.S. 563. (1975).

Onken S., Craig, C., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 1*(9), 9–22.

Plat, M., Sabetti, J., & Bloom, D. (2010). The transformation of mental health services to a recovery-oriented system of care: Canadian decision maker perspectives. *International Journal of Social Psychiatry*, *56*(2), 168–177.

Roberts, G., & Wolfson, P. (2004). The rediscovery of recovery: Open to all. *Advances in Psychiatric Treatment, 10*(1), 37–48.

Satel, S. & Zdanowicz, M. (2003, July 29). Commission's omission: The President's mental-health commission is in denial. *National Review Online.* Retrieved from http://www.nationalreview.com/articles/207650/commissions-omission/sally-satel.

Slade, M., Amering, M., Oades, L. (2008). Recovery: an international perspective. *Epidemiologia e Psichiatria Sociale*, *17*(2), 128–137.

Solomon, P., Cavanaugh, M., & Gelles, R. (2005). Family violence among adults with severe

mental illness: A neglected area of research. *Trauma, Violence, and Abuse, (6)*1, 40–54.

Srebnik, D. & Russo, J. (2008). Use of psychiatric advance directives during psychiatric crisis events. *Administration and Policy in Mental Health, 35*(4)*,* 272–282.

Stewart, M. (1995). Effective physician-patient communication and health outcomes: A review. *Canadian Medical Association Journal*, *152*(9), 1423–1433.

Substance Abuse and Mental Health Services Administration (2010). Examples of Mental Health Decision Aids. Retrieved from http://download.ncadi.samhsa.gov/ken/msword/SDM_fact_sheet_7-23-2008.doc.

Szasz, T. (1960). The myth of mental illness. *American Psychologist, 15*(2), 113–118.

Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14. (Cal. 1976).

Torrey, E. (2002, April). Hippie healthcare policy: While one government agency searches for the cure to mental diseases, another clings to the '60s notion that they don't exist. *Washington Monthly, 34*(4), 17–21.

Treffert, D. (1973). Dying with their rights on. *American Journal of Psychiatry, 130*(9), 1041.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General—executive summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Van Dorn, R., Scheyett, A., Swanson, J., and Swartz, M. (2010). Psychiatric advance directives and social workers: An integrative review. *Social Work, 55*(2), 157–167.

Wolpe, P. R. (1998). The triumph of autonomy in American bioethics: A sociological view. In R. DeVries & J. Subedi (Eds.), *Bioethics and Society: Constructing the Ethical Enterprise* (pp. 38–59). Upper Saddle River, NJ: Prentice Hall.