A Framework for Support

Third Edition

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CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

A Framework For Support: 3rd Edition

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A Framework for Support: 3rd Edition

Since its inception in the early 1980's, the Framework policy project has called for the full involvement of consumers and families in mental health systems that are community focused and recovery oriented. In support of this, the Framework identified four key interest groups with the potential to integrate and support people with mental illness[1]. The *Community Resource Base*, as these four groups are collectively called, reflected a shift in thinking by including consumers and families as full partners, along with mental health service providers and representatives of generic social agencies, in the process of planning and operating the mental health system. These ideas of partnership, and the redefinition of consumers and families as key players and change agents with a wealth of practical and experiential knowledge, have proven to be enduring components of the Framework model. They are the foundation for a policy approach that is centred on the lives of people with mental health problems, not just the professional service system that is designed to help them.

In 1993, a new and revised Framework was published. The new document built on the work of the original model, and in particular the work of expanding our sources of knowledge and understanding. It did this by adding a foundation of "the elements of citizenship" (regular work, housing, education, and income), and a new concept to complement the *Community Resource Base*. The *Knowledge Resource Base* identifies the main sources of information and understanding that shape how we think about mental illness. By adding experiential and cultural/traditional knowledge to the more recognized scientific approaches, it offers a map designed to enrich our ability to make sense of the complex individual and social issues faced by consumers.

A Framework for Support: 3rd Edition continues the commitment to both partnership and a person-centred approach to mental health policy. The 3rd Edition also continues the tradition of innovation in the Framework policy model by introducing a new fundamental concept aimed at better articulating what "person-centred" should mean. The *Personal Resource Base* is designed to complement the Community and Knowledge Resource Bases by offering a new way of looking at the inner lives of consumers, and in particular at the capacities they have identified as essential to coping with mental illness. Just as the *Community Resource Base* moved the mental health treatment system from centre stage in our thinking about community support, and the *Knowledge Resource Base* recognized the importance of adding experiential and cultural/traditional understanding to the scientific sources of our knowledge of mental illness, the *Personal Resource Base* is designed to move negative concepts grounded in pathology and disability from the centre stage of our understanding of consumers. The point is not to reject the important role of diagnosing and treating illness and understanding disability, but rather to put these in a broader frame of reference by recognizing and supporting the skills and capacities that consumers bring to living with mental illness and recovering from it. As with the other basic concepts of the Framework model, the goal of the *Personal Resource Base* is to build connections and partnerships that will enhance our collective capacity to support consumers and enhance their capacity to deal with the challenges of illness and move towards recovery.

The central goal of any mental health policy should be simple. A good policy will start with people, not systems, and seek to build new and creative ways of understanding their needs. It will then use this foundation to direct the available public resources to support these needs.

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[1] The term "mental illness" is used here for convenience. It is recognized that some of the many cultural groups that make up Canadian society have different ways of conceptualizing the phenomena that are referred to as mental illness. Some members of the consumer community also have different ways of conceiving the issue.

The Framework model makes the following characteristics central to policy:

1. Transformation and hope:
- Collectively, we have the skills and knowledge to dramatically change our approach to mental illness.
- As a result, people with mental illness can look forward to better lives in the community.

2. Respect and recognition:
- The starting point is the actual process of people with mental illness living their lives in the community, not set notions of "mental illness" or "mental health services".
- People with mental illness are seen first as citizens with a wide range of capacities, skills, and talents.

3. Moving forward in partnership:
- Partnerships of people acting for change are at the centre – partnerships of consumers, professionals, families, and policy makers.
- Partnerships of knowledge show the way – partnerships of medical and other clinical knowledge, social scientific knowledge, experiential knowledge, and the rich base of cultural and traditional knowledge that can be found in Canada.

If we accept these priorities, it becomes clear that the Framework model calls for a change in policy thinking that is Copernican in scale. The message is simple: we need to fundamentally change many aspects of how we now understand and serve people with mental illness. If we listen carefully, we will hear consumers saying that they want to live as full citizens and to take their rightful place in the lives of our communities.

Based on this, the goal of the Framework project is unchanged in the twenty years that have passed since its inception:

TO ENSURE THAT PEOPLE WITH SERIOUS MENTAL HEALTH PROBLEMS LIVE FULFILLING LIVES IN THE COMMUNITY

Introduction

People with mental illness, their families, and the mental health professionals who try to support them are currently in a state of dynamic tension. At no other time in history have there been in place the knowledge and understanding, the range of techniques, and the human resources to create the kind of revolutionary change in the lives of consumers that is now possible. New therapies, the emergence of evidence-based programs, a new awareness of population health factors, and consumer and family empowerment all contribute to this powerful mixture.

The source of the tension is clear. It can be found in the gap between what we know we can do and what we are actually doing. We can intervene early in psychotic illness and dramatically improve its course, but in most cases we do not. We can house people effectively in ways that support independence and dignity, but in many cases we do not. We can support people in regular work and school settings, but in most cases we do not. We know that consumers can help each other if they have the resources, but in most cases they do not. The list could be longer.

Balancing these problems are successes. There are dozens of examples of effective and successful programs, treatments, and other models of support that are now in place and operating. There is also a rapidly increasing number of consumer and family stories that speak volumes about the possibility of recovery and a dignified life in the community. These stories show that the future is to some degree already at hand.

If the ingredients of change are in place, what is holding us back? There are many factors, with perhaps political will, imagination, and money being the top three. Political will is needed at a time when stigma and discrimination against consumers remain stubbornly entrenched. The ability to imagine, to look at the situation now and see in it the seeds of a different future, is also vital. This applies to the imagination of the public about their fellow citizens, of families about their relatives, of consumers about themselves, and of professionals about their clients. Money is needed to shift to new programs and ways of providing support, but it is money well invested in the long term because the individual and social costs of mental illness are lowered.

The Framework for Support focuses on three core areas to mark the way forward. The three areas are community, knowledge, and the personal resources needed to cope with mental illness. The focus on community serves to anchor our thinking in the real process of consumers' lives in society. It balances the service-focused bias of older policies by calling for full partnerships with consumers and families, and by recognizing the complex range of factors that shape the lives of consumers in the community. The focus on knowledge offers a model that fully engages the wide range of knowledge that we now possess. This includes, but goes beyond, best practices and evidence-based concepts to outline a rich convergence of kinds of understanding that range from the scientific to the experiential. The focus on personal resources redefines the inner landscape of consumers from a repository of illness and symptoms to a dynamic mixture of skills and capacities that can successfully confront illness. Taken together, these focal points and other elements of the Framework model describe a process for moving ahead.

Structure of the Framework Model

The major goal of the Framework model – people with serious mental illness living fulfilling lives in the community – requires a clear vision of the future if it is to become a reality. We start with three fundamental assumptions and three conceptual models to address them:

- That the way in which Canadian communities provide services and supports to people with mental illness needs to be reformed and restructured. Part 1 of the Framework outlines a conceptual model, the *Community Resource Base*, which rethinks the nature of services and supports.

- That the most basic ways in which we think about and understand mental illness need to be re-examined and changed. Part 2 of the Framework proposes a conceptual model, the *Knowledge Resource Base*, which brings into focus the diverse kinds of information relevant to this task.

- That the way in which consumers are seen as people needs to be changed and enriched with a focus on the capacities required to successfully deal with mental illness and enhance mental health. Part 3 of the Framework introduces the concept of the *Personal Resource Base* as a model for understanding consumers as actors who can direct their own recovery process.

The first of these assumptions, that services and supports need to be reformed and restructured, is widely accepted across Canada. Most provinces now have plans to change services and develop new models, though the service paradigm still dominates the search for solutions. It is hoped that the concepts and ideas that flow from the *Community Resource Base* and are outlined in Part 1 will continue to shift the balance so that non-service approaches are included in our thinking, and will contribute to this process of reform.

The second assumption, that our fundamental understanding of, and attitudes towards, mental illness need to be rethought, is less a part of the current debate in the field. The point is not simply that public attitudes need to be changed, but that important aspects of the knowledge base available to us are ignored or under-utilized by many groups including professionals, policy makers and the public. The knowledge base that is available in Canada today is in fact extensive. On the one hand, mental illness has been formally studied by both clinical disciplines and the social sciences. On the other hand, rich cultural and ethnic traditions in Canada represent knowledge from past and present experience. More recently, consumers have begun to develop and communicate their own ways of thinking about and understanding mental illness. Families, too, are able to contribute to our understanding on the basis of their intimate association with consumers. All of these approaches have strengths and weaknesses. But whether the issues are negative, such as stereotypes in the media or narrow clinical perspectives which ignore social factors, or positive, such as the new insights provided by consumers exploring the direct experience of mental illness, the point remains the same. The various types of knowledge that we have are not being effectively synthesized and utilized. This area is explored in Part 2 using the *Knowledge Resource Base*.

The third assumption, that how we see consumers, and how they see themselves, needs to be re-evaluated and enriched, is an ongoing topic of debate in Canada. For many years, consumers, members of the family and professional communities, and the Canadian Mental Health Association have been fighting against limiting and disabling views of consumers. These important efforts have been enhanced by the emergence of consumers as advocates, members of planning groups, and as staff in mental health agencies. Despite many successes, impoverished views of consumers and their capacities linger on in the public, and particularly in the professional, imagination. Fortunately, efforts aimed at positive change continue. The *Personal Resource Base*, discussed in Part 3, brings focus to these and many other complementary efforts to change how we see people with mental illness, and articulates the steps people can take on the road to recovery.

Health policy is a rapidly changing field that generates new theories and paradigms to help make sense of the complexities of human health and well being. Health promotion, population health, and best practices are examples of perspectives that have relevance to how we think about and implement health strategies at the broadest level. The Framework model, on the other hand, focuses specifically on issues faced by people with serious mental illness. The sections below discuss how the Framework incorporates these important trends in health policy and expresses them in the particular field of serious mental illness.

The Framework and Mental Health Promotion

In the past several decades, health promotion has become an increasingly accepted approach to health and wellness. Growing out of the health promotion tradition is a concept of mental health promotion that builds on the same principles of individual and community choice, control, and participation in decisions about health issues and ways to address them.

The Framework model, although developed largely outside the mental health promotion field, has many elements in common with mental health promotion. It recognizes the importance of the knowledge and experience of people with mental illness and their families, emphasizes participation in decision making as well as power and control, and focuses on the promotion of mental health and the journey to recovery rather than on simply treating the illness. It can accurately be seen as a mental health promotion model for people with mental illness.

In fact, the model has been used to launch discussions about promoting the health of other target groups. By replacing the person in the centre of the model with other special populations such as seniors or isolated adolescents, it has proven possible to explore new options for mental health promotion.

The Framework and Recovery

Academic research and writings by consumers have successfully challenged the traditional belief that serious mental illness must by definition follow a chronic and deteriorating course. The new perspective is more optimistic and recognizes the reality of recovery. The term recovery, when applied to mental disorders, has a different connotation from the common understanding of recovery in regard to physical illness. Whereas recovery from physical conditions usually implies the absence of illness, recovery from serious mental disorders is a more nuanced phenomenon that may coexist with ongoing symptoms. Consumers' descriptions of their own experiences are key to any understanding of recovery.

William Anthony, a leader in the field of psychosocial rehabilitation, talks about how recovery involves the development of new meaning and purpose in life as an individual grows beyond the catastrophic effects of psychiatric disability. It can be seen as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and roles and as a way of living a satisfying, hopeful, and contributing life. Because recovery is often described in terms of gaining control over one's life and the illness (rather than the illness having control over the individual), recovery has significant commonalities with mental health promotion.

The recovery perspective is fully consistent with the Framework. The elements that support recovery, including meaningful daily activity (such as work or education); positive family or peer relationships; medications; and recovery-oriented mental health services, are put in a conceptual context in the Framework model. The model also encompasses the idea of a new understanding of illness and of the individual capacity to cope with the challenges it creates. Recovery and the Framework model are discussed more fully in the conclusion of this document.

The Framework and Population Health

Like mental health promotion, the population health approach differs from traditional medical thinking. In an attempt to influence the health status of the population as a whole, it draws on the growing body of evidence about the social and environmental factors that determine health. Work, income, education, housing, and peer and family supports are examples of population health factors. The Framework identifies these factors and describes their importance in working with, and reducing the burden on, more traditional health serivces. By doing so, it attempts to create a unified strategy to promote the overall well being of people with mental illness.

The Framework and Best Practice

Best practice is a way of putting into place health care that is evidence-based. The attempt is made to distill both the available scientific knowledge and practical examples of successful programs and policies into the best strategies for the operation of the health system and the care it provides. In the mental health field in Canada, the 1997 Report on Best Practices in Mental Health Reform, issued by the Federal/Provincial/Territorial Advisory Network on Mental Health, offers guidelines consistent with this approach. The report has been very influential at the program and policy levels and has helped to shape the reform strategies of most provinces and territories.

The Framework is compatible with the best practices approach and foreshadowed it by calling in earlier editions for evidence-based models in mental health services and recognition of the contributions of consumers and families. The Framework itself was recognized in the 1997 report as a best practice in mental health policy.

Part 1: The Community Resource Base:
Developing Comprehensive Services and Supports

Introduction and Concept

The *Community Resource Base (CRB)* rethinks the traditional approach to mental health policy and service development. It assumes the perspective of the person in the centre: the person who is actually living and coping with a serious mental health problem. The vast majority of consumers now live most of their lives in the community and are impacted by a wide range of factors besides mental health services. By looking at the whole process of people's lives, the CRB model introduces a more comprehensive notion of what policy should seek to influence.

In the past, mental health policy has been based on what can be called the "service paradigm". This view assumes that the exclusive focus of policy should be formal services, and that it is these services that are the primary determinant of outcome. The service paradigm was developed by professionals and reflects the professional point of view. It is also a natural outgrowth of the history of service provision to people with mental illness, whereby all services, medical/clinical as well as vocational rehabilitation, recreation, nutrition, housing, and so on were provided in the hospital. In the early decades of deinstitutionalization this way of thinking continued to dominate, with policy makers attempting to replicate the same kinds of services, but outside the hospital in the community.

As a result of these influences, most policy makers still come to their task with a map of the service system in their heads and a goal to develop policies that will deliver better services. But, by assuming this narrow focus, they are seriously limiting the range of options that could be considered if other kinds of resources and experience were tapped.

In contrast, the CRB model takes a different starting point. This new approach is called the "community process paradigm". It fully recognizes the importance of mental health services, but goes further to include the role of families and friends, generic services and supports, and consumers working together on their own behalf. It also acknowledges the fundamental elements of community to which every citizen should have access: housing, education, income, and work. Taken together, the components of the CRB comprise the various elements that individuals with serious mental health problems need in order to live a full life in the community and to maximize their potential for recovery.

The Community Resource Base: Map

The Person in the Centre
The person with a serious mental health problem, as the focus of concern of the Community Resource Base, is central in the diagram. The central position implies that the person has opportunities to be an active participant in the community, and has decision-making power about not only mental health services, but also about the choice of which of the supports of the Community Resource Base, if any, are the most appropriate at any given point in time. The centrality of the person also implies that the person, not the system, must be the focus of policy. The person in the centre is explored in detail in this document in the section on the Personal Resource Base.

Community Resource Base
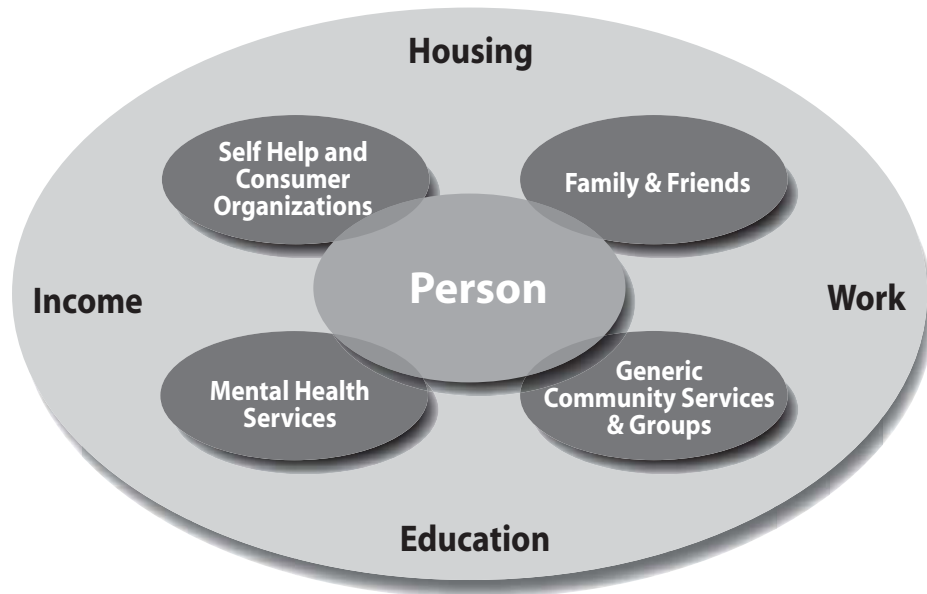
The foundation of the Community Resource Base – Housing, Work, Education, Income, and other basic elements of Citizenship.

Self Help and Consumer Organizations

An important resource, steadily growing in strength, is that of consumers themselves. Organized in groups, and with adequate financial support and organizational training where necessary, consumers can collectively meet many of their mental health needs.

Within this category, self-help/mutual support is the longest standing and perhaps the most obvious activity. In the past few decades, self-help groups have been increasing dramatically in number and popularity for a wide variety of health and social issues across the population. It is natural, then, that people who have been through the mental health system would also make use of this resource. For this population, self-help groups offer profound benefits. They not only provide the opportunity to share emotional and tangible support, but they make use of people's own strengths and capacities as sources of help for others. Based on principles of shared experience, joint ownership and leadership, and free of monetary considerations, self-help/mutual support represents a fundamental tool to allow people to work together and take charge of their own lives.

In recent years, the array of initiatives that consumers control themselves has expanded beyond self-help/mutual support groups to include other activities. For example, there are consumer-run advocacy groups and networks, consumer-operated businesses, consumers training other consumers in skills development, and consumers developing a base of knowledge for themselves.

There are several ways that recent consumer-run initiatives have diverged from a traditional self-help model. The explicit emphasis is not only on mutual support, but more outward-directed activities such as the examples listed above. And, unlike pure self-help/mutual support groups, some of these initiatives require a base of financial resources in order to be viable, and some have structures that include staff as well as volunteer leadership.

Nevertheless, these activities emerge out of the concept of self-help/mutual support; they are built on groups of people coming together on the basis of their common experience, and they involve people drawing on their own strengths to help themselves and one another. As with pure self-help/mutual support groups, these organizations are distinct from formal mental health services in that all the activities are generated by and controlled by the consumers themselves, working together.

Mental Health Services

Mental Health Services consist of the various hospital, community agency, and private-practice based options available in a particular community. This formal mental health system of physicians, nurses, social workers, psychologists, occupational therapists, and other professionals is an important resource. It not only provides treatment, but often supports recreation, housing, and other aspects of community life.

Until relatively recently, the prevalent professional view was that people with serious mental illness had no hope of recovery, and the main roles of the formal mental health system were maintenance and control. This is no longer the case. A range of recovery-oriented models, such as psychosocial rehabilitation and early intervention, is now available. If these models are adopted, the formal mental health system has a vital role to play in community support.

Family and Friends

Families are the single largest group of caregivers, often providing financial, emotional and social support, although their role generally goes unrecognized. Families, when organized, have the potential not only to support their ill relative, but to provide support to one another and to other families as well.

Despite the importance of the role families play and the burden they carry, they receive almost no financial support. It is ironic that professional service providers, who provide care and support to people with mental illness, receive almost 100% of the mental health dollars, while families, who also provide care and support, receive virtually no financial resources.

For many people, informal networks of friends or neighbours fill the same functions as families. These networks provide a variety of kinds of support and the opportunity for reciprocal relationships not usually found in the system of formal services.

Generic Community Services and Groups

For many people, generic social services such as welfare benefits, public housing, and family services are even more important than formal mental health services. Generic social services should be figured into any discussion of community resources, as their role in the lives of people with serious mental health problems is significant. For example, when income supports are inadequate, or the episodic nature of mental illness is not recognized in income support policies, the impacts on people with mental illness can be devastating.

In addition to services, there is also a rich network of generic groups and organizations that contribute to life in the community. Religious organizations, interest-based groups (such as gardening clubs and sports clubs), and service clubs (such as Kiwanis and Rotary) provide the opportunity for meaningful involvement in community life that is outside the realm of mental health or professional services.

The Foundation

The foundation of the Community Resource Base is made up of the elements of citizenship. People with serious mental health problems, like everyone else, need to be connected to the natural community through a web of supportive contacts. Without the fundamentals such as jobs or other productive activities, good housing, appropriate education, and adequate incomes, people are pushed to the margins of society and deprived of the kinds of support that they need if they are to survive the challenges of living with a mental illness. In addition to these primary elements, there are also other important factors, such as recreation and leisure, which contribute to a full life in the community.

The foundation, by underlying and giving context to the Community Resource Base, emphasizes the fact that all services and supports must work to enhance the individual's role as a citizen. It can also be seen as a grouping of social factors that determine mental health, consistent with the health determinants that have been identified by Health Canada.

1. Shifting the Perspective
All too often, the perspective in planning mental health services is that of the service provider. In contrast, the Community Resource Base is a picture of what is needed, seen from the perspective of the person in the centre of the picture. The perspective of the individual is paramount, and must be considered by all the stakeholders. The CRB is a reminder that all policy development and program delivery should start by listening to consumers.

2. Drawing on a Range of Resources
The Community Resource Base is an ideal picture of the range of resources that should be available to a person with serious mental health problems. If a person is to live a full life in the community, all the resources in the CRB must be mobilized.

3. Moving Beyond the Service System
The Community Resource Base shows that many resources beyond formal services enrich people's lives. Equally important are the informal supports of family, friends and community, access to income, housing, jobs and education, and the solidarity that can come from membership in consumer groups and organizations. As a result, the CRB implies a shift from the service paradigm to the community process paradigm.

4. Forming New Partnerships
The presence of four balanced sectors implies that they work in partnership to support the person in the centre. While each sector provides its own unique kind of support, each must also recognize the importance of the others, and work to enhance the strength that all can provide together.

5. Having the Power to Choose
The Community Resource Base is not just about support, but about participation and choice. The person in the centre has the power to make choices about which resources, if any, to utilize, and can participate fully at the decision-making level in all areas of community life.

6. Planning Mental Health Services
All the sectors of the Community Resource Base need to be involved in mental health planning. However, the CRB is not a picture of the proportionate representation that must always be at the planning table, and does not imply that, when planning mental health services, only one-quarter of those at the table should be consumers. Naturally, when planning services that directly affect consumers, their representation on the planning group should be much higher. Other representation should be determined by the planning task at hand.

7. Developing Comprehensive Strategies for Change
Those interested in mental health reform must remain aware of all aspects of the Community Resource Base when selecting targets for advocacy. Perhaps it is the service system that most needs to be targeted for change, but in other instances it may be generic community organizations such as churches which can be educated about inclusion of consumers in their programs, or generic real estate developers, employers or educators who should be targeted to promote access for people with mental health problems. In addition, action can be taken to help make generic services such as disability benefits more sensitive and accessible to people with mental health problems.

8. Allocating Resources
At present almost all resources for mental health are allocated to formal services. In order for all the sectors to play their parts effectively, however, resources must be more equitably balanced.

Part 2: The Knowledge Resource Base: Developing a New Understanding of Mental Illness

Introduction and Concept

Part 1 of the Framework examined the services and community supports that are needed by people with serious mental health problems and suggested a variety of areas in which changes are needed. The key concept, the *Community Resource Base*, outlines the stakeholders involved and suggests ways of thinking about their needs and mutual relationships. The approaches outlined reflect a number of trends currently evident in mental health policy, and offer ideas and strategies for future development.

There is good reason to hope that the implementation of these approaches will result in real improvements in the lives of people with serious mental health problems. But there is also reason for concern. The current era of mental health reform in Canada is not the first time that efforts have been made to bring about fundamental change. Previous efforts (such as the moral treatment movement of the nineteenth century and deinstitutionalization in the 1950s and 60s) had humane and idealistic goals, but failed to fully attain them. The question is, why?

The reasons are no doubt complex, but two stand out. The first is that previous efforts at reform failed to redefine the role of consumers. Although consumers were brought into sharper focus as objects of charitable concern, they were not included as empowered partners in the ongoing process of providing services and supports. Now, in addition to receiving services, consumers are being recast as providers of these services, and as operators of their own base of organizations.

The second reason is related to the most basic ways in which we think about and understand mental illness. The answers to fundamental questions – what is mental illness? how do we react to it? – play a crucial role in shaping our action. In Canada and other Western countries we tend to assume that the answers come largely from psychiatry and other professional perspectives, and this is a mistake. The psychiatric and professional perspectives are very important, but other sources of knowledge exist and recognizing them can greatly enhance our understanding. There are other voices to be heard.

The experience of the women's movement offers an important example. Women, in their drive towards equality, have drawn attention to the ways in which society has traditionally ignored their perspective. Their efforts have resulted in a striking change in how we see fifty percent of the population. They have forced society to recognize the systemic barriers to equality associated with traditional modes of processing information and disseminating knowledge. The resulting critique of gender bias in areas such as domestic relations and workplace roles has led to the redefinition of women and their capacities.

Insights associated with this emerging understanding are particularly relevant in the field of mental health and hold real promise for changing the way in which another large group of individuals is perceived. We need to understand mental illness in a richer, more complete fashion, and to understand it in a way that furthers our ability to support consumers as valued citizens. This means that building knowledge is not simply an abstract, academic pursuit. We need to build knowledge that is about something, and that something is people with mental illness living full lives in our communities.

For consumers, who are often living on the margins of society and are subject to offensive and stigmatizing messages in day-to-day social life, the need for knowledge that can bring them a greater measure of freedom and dignity is a real and concrete issue. Thinking of research in this more focused way, and tying it to emancipation and empowerment, opens the door to building a richer understanding of mental illness.

The *Knowledge Resource Base (KRB)* is the conceptual foundation for building this richer understanding and is made up of the types of knowledge that are available to understand and make sense of mental illness. The KRB was developed using a mapping approach aimed at identifying all the sources of knowledge that we actually use in everyday life. It is an attempt to go beyond the notion that real knowledge is only in the hands of the clinical experts, and that others (such as consumers, families, and the public) have little to contribute. By recognizing this wider field of knowledge, its goal is to promote a constructive dialogue that will lead to a more balanced and comprehensive understanding of mental illness.

The Knowledge Resource Base: Map

Knowledge Resource Base

Recognition of Diversity

Experiential Knowledge

Customary/ Traditional Knowledge

Social Acceptance & Inclusion

Transforming Our Understanding of Mental Illness

Mental Health Literacy

Social Science Knowledge

Medical/ Clinical Knowledge

An Enriched Range of Services & Supports
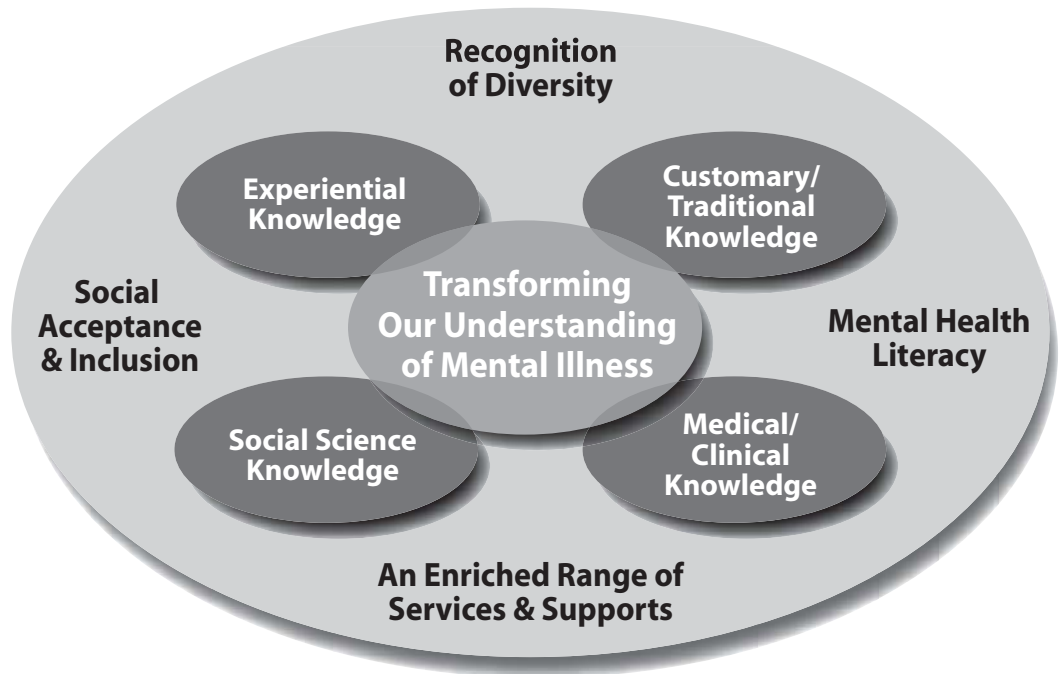
The foundation of the Knowledge Resource Base – Recognition of Diversity, Mental Health Literacy, An Enriched Range of Services and Supports, and Social Acceptance and Inclusion.

Medical/Clinical Knowledge

In Western countries the medical/clinical knowledge base pertaining to serious mental illness has been most thoroughly developed by psychiatry and clinical psychology. Both disciplines have copied the methods of natural science in becoming research based, and their findings are incorporated by the other mental health disciplines such as social work and nursing. There is a wide range of approaches within the clinical disciplines, from traditional physical illness models that emphasize drug treatment, to intra-psychic models that emphasize psychotherapy.

In addition to (or in partnership with) the mental health disciplines, there is important work being done in other areas. Basic medical research, particularly the study of the brain, is advancing our understanding of the underlying mechanisms that are at work. Other disciplines such as clinical nutrition are also beginning to contribute new knowledge, and undoubtedly other medical scientific disciplines will emerge as contributors in the future.

Along with established Western approaches, other medical/clinical traditions are present in Canada. Chinese medicine, for example, has a separate but highly developed body of theory and practice and effort is being made to bring the two traditions together.

Social Science Knowledge

Social sciences such as anthropology, sociology, and social and community psychology have developed important perspectives on mental illness. Instead of using a medical or illness model with its focus on the individual, social scientists study the nature and influence of the social context. They are interested in such factors as social groups and classes, and the impact on mental health of variables such as unemployment, homelessness, and poverty.

The way in which the social sciences understand and interpret mental illness can be strikingly different from clinical approaches. To take the example of depression in women, clinical approaches have traditionally used intra-psychic or biochemical explanations and prescribed individual therapies. A social scientific perspective, on the other hand, might look at social factors that shape the lives of women and affect their mental health. High rates of poverty, job discrimination, and psychological and physical abuse are seen as fundamental factors in explaining depression, and in determining practical courses of action. In practice, many mental health professionals combine medical/clinical and social science perspectives.

Experiential Knowledge

Consumers live with mental illness and know it more intimately than scientists or professionals who lack direct experience. As consumers, they know it from the inside. Their knowledge ranges from the immediate reality of symptoms to the impact of mental illness on their lives in the community. From this perspective, they know what mental illness is in a very important way. Though consumers are increasingly documenting their experience, this information is too often dismissed as anecdotal, rather than recognized as a useful source of knowledge.

To a consumer, the symptoms of mental illness are a profound personal experience. While we often assume that the medical explanation tells the real story, and that the consumer's direct experience is just a result of a chemical imbalance, this is often not the case. If a person develops severe mental health problems as a result of life events such as childhood abuse, loss of loved ones, or other external factors, the real story of their symptoms is not just in brain chemistry. It is also in their life. Even if, in another case, the direct cause of the illness has to do primarily with brain chemistry, the experiential component is essential to a full understanding of what is going on and to effective intervention.

In addition to consumers, families can contribute in their own way to the experiential understanding of mental illness. Although organized family groups have tended to adopt the medical/clinical perspective, as individuals these same family members have extensive knowledge of the day-to-day realities of mental illness. They see the impact on loved ones, and what it means in a larger life context. This experience has led family organizations to become strong advocates for access to education, work, and full participation in community life. Their insight into the fact that a full understanding of mental illness includes recognizing the way in which illness and life circumstances interact is a valuable addition to our understanding.

Customary and Traditional Knowledge

This category refers to a variety of ideas and concepts about mental illness. Customary here means the kind of knowledge that people receive informally from family, friends, and their community, but not from organized formal systems such as medicine and social science. Included are such components as public attitudes and the conventional wisdom of understanding and responding to the people who are affected by mental illness.

Anyone, in any society, is exposed to customary and traditional ideas. If we talk to a cross section of people who have no direct experience as consumers and no scientific training, their knowledge and understanding of mental illness will reflect customary and traditional knowledge. For example, they might believe that people with mental illness need support

from their family and friends, and meaningful tasks to occupy them during the day. Unfortunately, they might also hold rather derogatory or stereotypical notions of mental illness that will stand as barriers to meaningful integration of consumers into the community.

The Foundation

The foundation of the Knowledge Resource Base is made up of the outcomes of a more comprehensive approach to knowledge and of the impacts that such an approach will have. The foundation grounds the KRB in ways that are helpful and practical to both consumers, families and providers.

The Knowledge Resource Base: Implications

1. Recognizing Variety

The KRB brings into focus the various types of knowledge that can contribute to an enriched understanding of mental illness. In the past, some of these have been ignored or undervalued.

2. Building A Rich Resource

The components of the KRB represent a tremendous accumulation of experience and knowledge. Taken together, they form the base from which Canadian society can transform and enrich its understanding of mental illness.

3. Developing a Critical Analysis

The components of the KRB all have strengths and weaknesses, and there are many examples that illustrate the need for critical analysis. For example, medical/clinical approaches have often stressed a narrow illness model. One result has been an inadequate understanding of the complex issues of day-to-day life for consumers and an overriding emphasis on drug and hospital treatment. Another example is the negative aspects of some customary and traditional knowledge. In Canada, public attitudes to mental illness have many inaccurate and dubious features, as well as positive and humane ones. All the components of the KRB need to be analyzed for the positive contributions that they can make.

4. Taking Down the Barriers

By providing a map of the various types of knowledge that contribute to our understanding of mental illness, the KRB highlights the need for better communication. The need for better communication highlights the need to remove the barriers that restrict our current thinking about mental illness. The full value of listening to other perspectives can come only if we actively attempt to integrate them into new and more balanced perspectives. Dialogue and mutual learning are the cornerstones of this process.

Moving Forward

The Knowledge Resource Base, with its emphasis on a balanced understanding of mental illness, sheds light on the most fundamental problem faced by consumers today. On the one hand is a treatment system that is, by international standards, very rich. It typically features up-to-date hospitals and highly trained staff. Canadian society, if viewed only in terms of its commitment to providing treatment, rates quite well. On the other hand are the realities of day-to-day life in the community. This presents a very different picture, one characterized in many cases by poverty, unemployment, and despair. By almost any notion of what it means to belong to a community and to fully participate in social life, Canadian society is cold and rejecting to people with serious mental illness.

The commitment to expensive treatment clearly stands in sharp contrast to the lack of commitment to the building blocks of community life such as housing, income, and work. From the perspective of the Knowledge Resource Base, our limited understanding of people with mental illness as citizens with the same hopes and dreams as anyone else lies at the heart of this contradiction. The current situation represents a biased and imbalanced use of the information available. The social scientific, experiential, and customary/traditional components have been largely ignored in favour of an overriding emphasis on medical/clinical knowledge and the institutional models that it generates. At the street level, this has left many consumers

living in poverty on a day-to-day basis until their symptoms increase and they become redefined as a "patient". At this point, society is suddenly prepared to provide five hundred dollar-a-day hospital treatment. This suggests that we can clearly understand people with mental illness as patients, but only dimly perceive them as fellow citizens.

In Canada, the fact that we have been unable to develop a practical and action-oriented understanding of consumers in a way that reconciles the gap between expensive treatment and social marginalization is tragic. From a variety of sources, including international research on schizophrenia, the writings of consumers, and research with families, it now seems clear that there is nothing more damaging to someone trying to deal with a mental illness than being cut off from a meaningful life in the community. Even the best service system cannot overcome this, and it is not surprising that, according to the World Health Organization, Western countries like Canada have worse outcomes for schizophrenia than some traditional areas in developing countries. Although treatment resources in these traditional areas are minimal, the ability to include people, and to recognize their potential as well as their fundamental humanity, is enriched. How can we learn from this? Can we change the way we perceive people with serious mental illness so that they are included more fully in society? This is the challenge of the Knowledge Resource Base.

Part 3: The Personal Resource Base: Developing a New Understanding of the Personal Resources Needed to Deal with Mental Illness

Introduction and Concept

People with mental illness in Canada confront a very significant challenge. They live in a society that expects a comparatively high level of performance in a variety of social roles, but they face this situation with extra burdens. Mental illness itself, as expressed within a person, creates a clear burden. The symptoms of depression, for example, or the cognitive problems associated with schizophrenia, in and of themselves create challenges for the person coping with them. A second kind of burden is the negative social attitudes, discrimination, and stigma that are externally imposed and make success in personal and social life more difficult to achieve.

Common sense suggests that consumers need to be equipped with significant personal resources to face the burdens imposed by mental illness. An enlightened mental health system would both treat illness and support the resiliency and personal strengths of those who deal with it. In fact, the traditional professional view of consumers has done the opposite. This perspective, which once seemed obvious and above criticism, painted consumers almost entirely in terms of their illness and its deficits, and saw them as passive recipients of care, not as active agents working on their own behalf. In some cases, the only positive characteristic that a consumer could possess was compliance.

The capacities of consumers to work, learn, form relationships, live independently, and to recover were underestimated by professionals, as was their ability to manage the illness and understand it. This poverty of professional imagination was all the more damaging because those who had it also had enormous power. They did not keep their views to themselves, but shared them with consumers and families and created a culture of disability that weakened the very resources that consumers most needed to survive and prosper.

Fortunately, the traditional professional view has been challenged for many years and has gradually been changing. This change has come in step with the process of consumers, families, and progressive professionals creating other ways of seeing people with mental illness. The most significant critique is from consumers themselves. They have written often and eloquently about the experience of facing life with a mental illness, and their words richly capture the struggles, victories, and defeats of the process. They speak of hope and resiliency, of strength gained, and, increasingly, of recovery. Consumers no longer see themselves as passive recipients of care, but rather as actors working to achieve understanding and control.

In addition to the role played by consumers speaking and writing about their experience, models of support such as psychiatric rehabilitation and case management have helped professionals to see personal strengths and abilities in addition to weaknesses. As a result, there is a growing realization that the illness and its symptoms are only part of the story.

The *Personal Resource Base (PRB)* is a way of reflecting these important changes. Its goal is to consolidate the gains made and to support further progress. The PRB creates a new model for how consumers can see themselves and how they can be seen by others. It is based on a balance between the reality and challenge of illness and the resources that are needed to deal with it and live a full life. It graphically represents a fuller view of people with mental illness by emphasizing more than just their mental health problem. The components, taken together, describe someone who feels a *sense of control* over their life – a critical element of mental health for all people. In this way the PRB directly reflects the approach to recovery that has been developed by consumers.

The PRB is best seen in close association to the Community Resource Base. It is a way of filling in the person in the centre of the CRB and giving context and texture.

Community Resource Base

Personal Resource Base
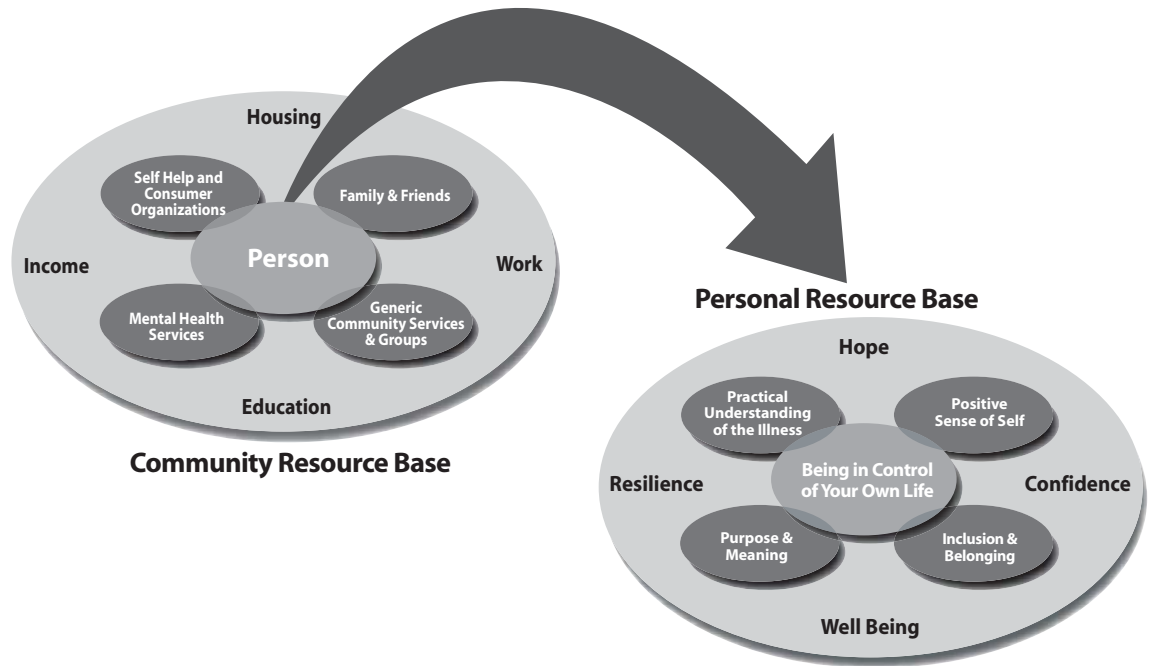
Personal Resource Base: Map

Personal Resource Base
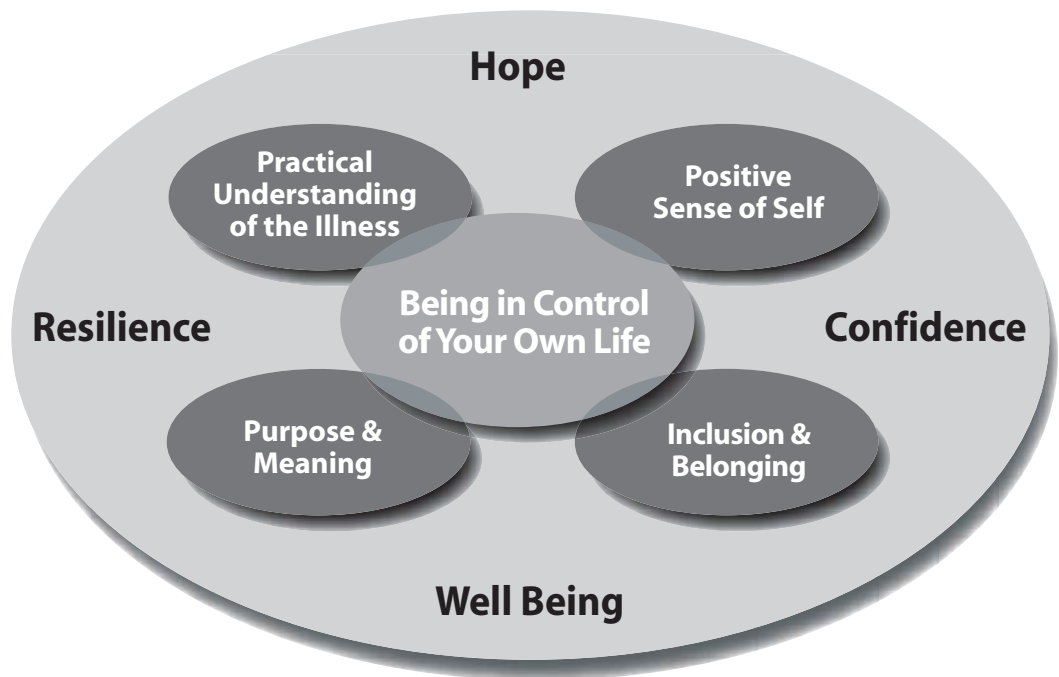
The foundation of the Personal Resource Base – Hope, Resilience, Confidence, and Well Being.

Four categories make up the PRB map.

A Practical Understanding of the Illness

People who confront mental illness must make sense of a complex array of factors. The direct experience of the illness and the reactions that it elicits in family and peers need to be absorbed and understood. This process can help or hinder a person's ability to deal with the situation. Making sense of the experience involves at least three factors:

1. the experience itself must be explained and classified;
2. its meaning for a person's sense of self and identity must be dealt with (for example, does the presence of the condition mean that one is damaged or inferior, or perhaps, as in some traditional cultures, that one is gifted); and
3. the impact on an individual's social situation and expectations must be confronted.

The results of this process of coming to grips with the illness are vitally important. As a person's own background and experience mix with input from family, friends, and professionals, an image of the illness and its impact begins to form. To do well, consumers need to develop a practical understanding of the illness. Doing this can lead to two positive results: a strategy to stay well, and a plan of action when ill.

A practical understanding may involve more than simple illness education. A person with recurring bouts of serious depression will certainly need to know about the signs and symptoms of the illness, and what treatments will provide relief. If, however, they are living in an abusive relationship, or have had a major loss in their lives, they also need to be aware of the impact that these contextual factors can have. In this sense, a practical understanding of the illness includes the kind of knowledge that will prevent a complex social situation being reduced to an isolated medical illness.

A Positive Sense of Self

Developing a positive sense of self is a basic tool for dealing with mental illness. Critical to this is the ability to separate the illness from the person. The labelling and stigmatizing of mentally ill people can result in an over-identification with the illness and a sense that it is all consuming and life defining. To challenge this is not to underestimate the impact of psychiatric conditions; instead it follows the lead given by consumers in their fight for recovery and dignity. Many consumers end up with what has been called a damaged self – a sense that they are, as people, broken in some way. Putting the illness in its place is essential to counteracting this. A key part of the PRB is the development of a sense of self that is separate from the illness and that is seen as having value and the chance to grow and develop throughout life.

Purpose and Meaning

All people strive to make sense of their lives and to develop a sense of purpose and meaning. People with mental illness have the extra challenge of doing this in the face of an illness that has traditionally robbed them of self worth and dignity. A sense of coherence – the sense that life is generally predictable and can be expected to work out reasonably well or, in other words, a feeling of some control – is vital to mental health as well as to coping with mental illness.

What comprises purpose and meaning for a particular individual may vary greatly. The development of spirituality, the connection to one's cultural or traditional values, a feeling of contributing to collective life as a citizen; all of these and many other factors may enter the picture. Naturally, a Native Canadian will be influenced by a different set of factors than a recent immigrant from the Sudan. What both will have in common with all consumers is the need to find purpose and meaning in their lives. The challenge for professionals is to be sensitive to this, and for consumers to develop this side of themselves.

Inclusion and Belonging

Mental illness is a very alienating experience for consumers. Social rejection may combine with an inner sense of isolation to exacerbate the challenges posed by mental illness. A sense of inclusion and belonging, on the other hand, can limit the impact of the illness and its capacity to separate a consumer from full participation in social life. Inclusion and belonging are the result of a complex interaction of factors: the illness, personal attitudes, and social circumstances as experienced by a consumer.

For most people, a sense of inclusion and belonging is not simply a fixed characteristic of their personality, but is dependent to an important degree on day-to-day interaction and messages received from others. Being in a position to receive these messages means being integrated into a series of social contexts. Our sense of inclusion and belonging is directly related to these social identities, for example in the workplace, in our families, and in settings such as religious institutions and service clubs. In the past, the impact of mental illness was overestimated and many routes to inclusion and belonging were blocked. Work for example, which many people see as essential to a positive sense of inclusion, was considered unrealistic for people with serious mental illness. Other social roles were also considered closed with the result that the building blocks of inclusion and belonging were missing. Developing a range of positive social roles is an important part of changing this.

The Personal Resource Base: Implications

The Foundation

The foundation of the PRB focuses on essential outcomes that contribute to recovery.

1. Recognizing the Essentials of Mental Health

The mental health needs of people who have experienced a mental illness are no different from those of anyone else. We all need "a home, a job, and a friend", a fact that has been articulated most clearly by consumers. In addition, knowing that we are valuable and important to ourselves and others, having a sense of why we are in this world and what we are striving for, and feeling that we have a clear role and place to belong all contribute to our mental health, no matter who we are. Even a practical understanding of the illness can be generalized to the broader population. No one gets very far in life without experiencing setbacks, crises, and even tragedies. Having the tools for understanding and dealing with these challenges is another essential element of mental health. Thus the categories of the PRB describe resources that are essential for mental health in general, and hence are common to all people, not just those with mental illness.

2. Building a Sense of Control

The feeling of being at the mercy of factors beyond our control is a recipe for stress, depression, and poor mental health in general. Unfortunately, this is too often the state in which people with mental illness find themselves. But all the components of the Personal Resource Base can add up to a sense of control over life. Even though not everything in life is controllable, with the right set of tools and resources in place it is still possible for people to make choices and take action on their own behalf. Knowing where we belong and where we want to go in life, feeling good about ourselves, and having the knowledge to deal with our particular challenges all contribute to a sense of control. And a sense of control, whether in regard to service options, workplace issues, or interpersonal relationships, is perhaps the most important element of mental health for all people.

3. Drawing on the Community Resource Base

The Community Resource Base (CRB) helps to answer the question of how to ensure the various personal resources of the PRB are in place. For example, what contributes to a positive sense of self, meaning and purpose, or inclusion and belonging? It could be connection to a faith community or interest groups (found in Generic Community Services in the CRB); it can be achieved through participation in the self-help movement, or through employment or education. How does a person gain understanding of the illness or of any mental health setback or challenge? It can come through education from the formal mental health system, through talking with family or friends, or through sharing experiences in self-help groups with others who have been through similar situations. The components of the CRB strengthen the resources of the person in the centre; the PRB highlights the person to describe these resources in detail.

4. Taking into Account the Time of Illness and Time of Life

Mental illness can strike a person at any age, but whatever their stage of life, it is the initial stage of the illness. This initial stage brings a series of challenges such as developing a relationship with the illness, dealing with its impact on sense of self and place in the world, and possibly with its impact on family and friends. The PRB provides a map to key areas that should be kept in mind in terms of the time or stage of illness.

Time of life is also important. The onset of a mental illness poses different challenges to a person who is sixteen than to a person who is sixty. The support offered needs to address the impact of the illness within the context of the time in the person's life. A young person may need focused support in completing the process of character formation and choice of roles, whereas a person in a later phase of life may need support in reconciling their established social roles to the new constraints posed by the onset of illness.

The PRB is a way of looking more fully at a person at any point in time, but the particular point in time is very important and should take into account both the time of illness and a person's time of life or stage of development.

Conclusion

Making the Future

What kind of perspective can we share that will allow us to make a better future? For many consumers, families, and professionals the obstacles to change can seem overwhelming. Poor service systems, the difficulty of developing new treatments, stigma, and alienation all contribute to what seems like a daunting set of tasks.

Perhaps the best place to find hope for the future is in the past, our own personal past as a consumer, or family member, or professional, and the past of the mental health system itself. Whether we look at the personal level or at the level of the mental health system, we see that tremendous changes can happen and that tremendous obstacles can be overcome. People who are close to the issues and who focus on the important problems that remain unsolved often miss this critical point. We need to recognize that all of our collective efforts have led to significant changes and improvements. It is easy to forget that within the living memory of many people was a system characterized by profoundly alienating custodial hospitals, the routine abuse of rights and incarceration of consumers, crude physical treatments such as lobotomy and insulin coma therapy, and a pervasive notion that people with serious mental illness could never recover. The idea of consumers working or living independently seemed ludicrous.

New hope now infuses the mental health field, whether it is better treatments, the power of self help, the success of many consumers in the community, or the revolutionary changes in our understanding of the capacities and strengths of consumers. The struggle for change has laid the foundation for a consolidation of gains and more importantly, a move to a new level. In this sense, we can have hope for the future because in many ways we have succeeded in the past, even if this success is still incomplete.

Having already engaged in personal and systemic struggles we can see stages in the process, and this look at the past illuminates the future. Many consumers, for example, in their personal histories of dealing with mental illness, remember the shock of first recognizing that something is wrong. All too often, this realization brings devastation and despair. Stimatizing attitudes that once applied only to others now come home to shake self-confidence and self-worth. Hope for the future and the feeling of belonging in the world are also shaken and may collapse. Family members often have similar experiences of the shock of recognition. Parents fear their children will never become productive adults and that a life of loneliness and hopelessness is what the future holds. Professionals, although usually dealing with their first encounters with mental illness in very different circumstances, frequently report feelings of fear and anxiety. Seeing people in institutional settings or on the street and realizing that the boundaries of human despair are far wider than one believed is a deeply unsettling experience. For everyone, initial encounters are life-changing events.

The shock of recognition is followed by initial attempts to cope, and how we cope is critical. In the past, when our understanding of mental illness was less developed and the messages given to families and consumers were often relentlessly negative, these attempts could be isolating and destructive. Denial on one hand, and the exaggeration of the illness and its impact on the other, characterized the responses of many consumers and families. Professionals attempted to help, but sometimes in ways that turned out to be harmful. Incarceration in custodial hospitals, destructive treatments, and the blaming of families are examples of this.

A critical result of this initial process of coping with illness was a high level of tension and conflict between the key stakeholders. In the past, many people did not get beyond this. There was no real basis for working together and the field remained fractured.

For many people, the shock of recognition and subsequent attempts to cope that are negative and isolating give way to a third and more positive stage. This change for the better comes when they begin to develop a sense of shared purpose and to work positively together to cope with challenges. For consumers this may mean connecting with other consumers or developing more productive relationships with professionals. Families also develop connections to others and form new partnerships. Professionals work better together and build alliances with consumers and families based on respect and dignity. **Everyone recognizes that at a time when inadequate service systems and social alienation are still the reality for many people, our shared interests far outweigh the issues that divide us.**

The most promising result of this is the convergence of a once fractured field into a cohesive force for change. We have all been through a difficult journey and have learned difficult lessons. This experience has built a greater recognition of common goals. Professionals are now more likely to see beyond treatment and understand the importance of community support, housing, and other determinants of health that consumers have long emphasized. Consumers are embracing the philosophy of recovery and recognize that good treatment and support from professionals are a key part of the process. Families also share the common goals of better treatment and supports in the community.

As a result, the situation today is very different than in the past. Consumers are no longer seen as without capacity or as being wholly defined by their illness. They are more likely to hear about hope and recovery. Families are less often blamed and their important role is becoming recognized. Professionals have effective treatments that can be of real help and rigorous research to make them better. On all sides, the serious challenges we face are sharing the stage with a sense of hope and excitement.

| **Realizing Recovery** | **Exploring the Necessary Constraints of Mental Illness** |

Exploring the Necessary Constraints of Mental Illness
We are now recognizing that what might be called the necessary constraints of mental illness, the constraints that are inherent in it and not the result of external factors such as prejudice and exclusion, can be much less significant than we imagined. This is a critical point, and one that is often seen more clearly in the context of other disabilities. In the case of spinal cord injury, for example, it is now a commonplace expectation that people with this condition will work and contribute to society in a wide range of ways. In fact, suggesting that people in wheelchairs should not work or have families would strike most Canadians as outrageous. It is sobering to think that as recently as the 1950s and 60s the idea of a person with paraplegia having a job was seen by many as novel and unrealistic.

The whole notion of the impact of this disability is now radically different. People in wheelchairs work, have families, play sports, and participate in all aspects of society. What has led to this change? It is perhaps clearest what has not led to the change. Despite the best efforts of scientists, spinal cord injuries still can't be cured. Finding a cure, as it turns out, has not been the key.

Dramatically changing the lives of people with spinal cord injuries has in fact been based on exploring the necessary constraints of the disability, and this process of exploration discovered that the constraints are much less than we had imagined. Being in a wheelchair, for example, proved not to be an inherent barrier to succeeding in the majority of jobs. Being unable to get to work, or to get into the building once you arrived, were barriers. But as transportation systems for wheelchair commuters and accessible buildings have shown, these were unnecessary, not inherent, constraints. By rethinking the nature of the disability, and by putting in place both the attitudes and infrastructure needed to support inclusion, the impact of the disability was redefined and dramatically reduced.

Although mental illness brings different challenges, the principle is exactly the same. If a person can work, but is prevented from doing so by stigma or by the lack of a workplace that offers the necessary accommodations (such as part-time work or job flexibility), they are facing a real but unnecessary constraint. If a person can live in independent housing with the support of a case manager, but is only offered a custodial setting, they are facing an unnecessary constraint.

The good news, however, is clear: we now know that most people with serious mental illness can work, live in independent settings, finish school, and do many other things. For those who can't, we are able to provide more support in ways that reflect dignity and empowerment. The unnecessary constraints that often prevent the full realization of people's capacities closely parallel the example of spinal cord injury and reflect a combination of negative attitudes and the absence of needed supports in the community. These unnecessary constraints are now being dismantled and we are discovering, step by step, the territory of full citizenship.

The emerging map of this territory is very exciting. Some of its landmarks are about how we see people and include understanding, dignity, and respect. Other landmarks show a new kind of life for consumers and include work, having a family, and being a valued citizen. Both kinds of landmarks are critical. Working hand in hand they support a profoundly different and new reality. In this new reality people with serious mental illness routinely succeed in school, find work in jobs that reflect their talents, have social and family lives in the same way as others, manage their illness with effective treatments, and see themselves as unique and valuable people.
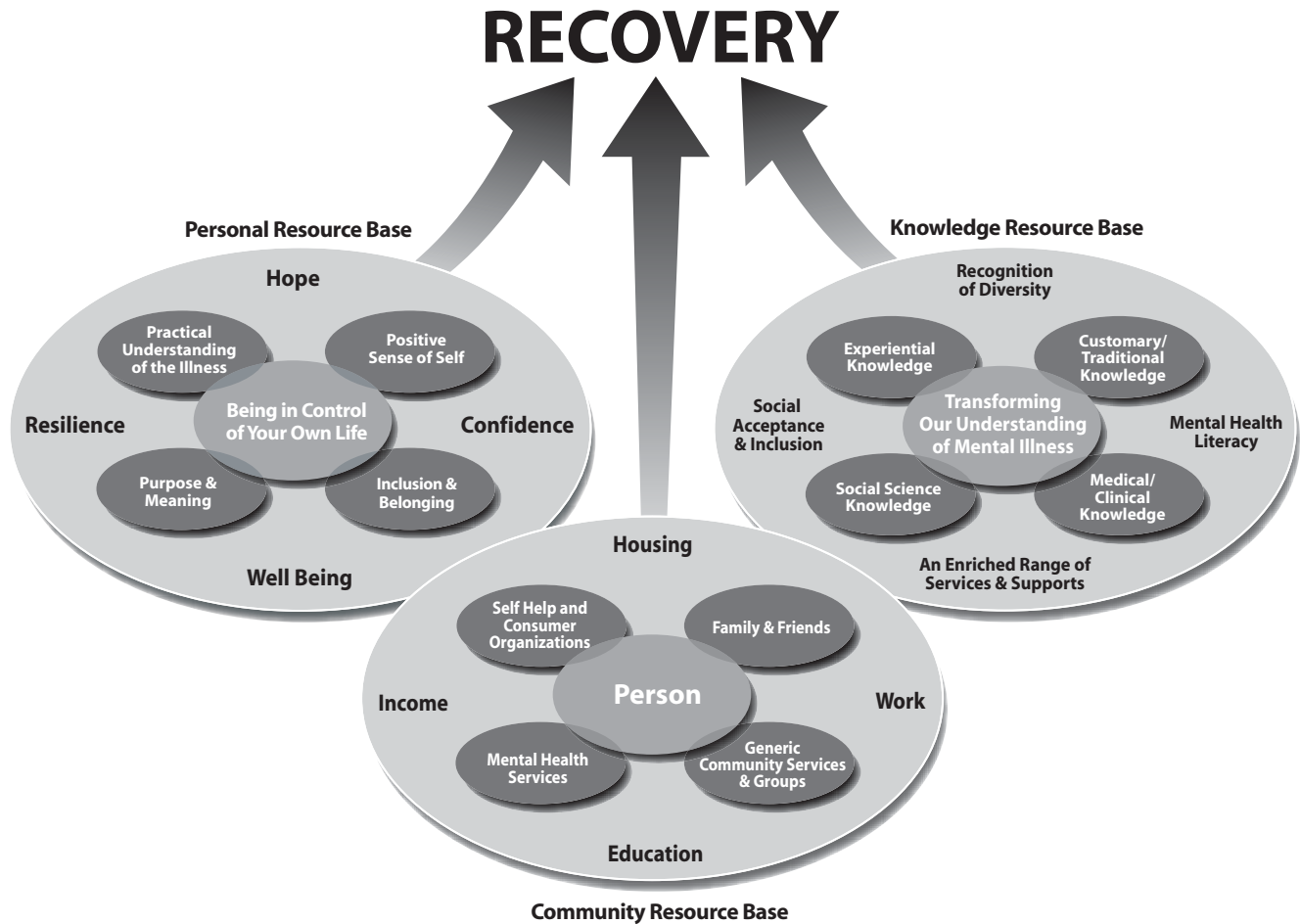
The Three Pillars of Recovery

The goal of the ***Framework for Support: 3rd Edition*** – to ensure that people with serious mental health problems live fulfilling lives in the community – will require dynamic and sustained change if it is to become a reality. We must improve the process of helping and supporting people with serious mental illness; we must enrich our basic understanding of what serious mental illness is; and we must change the way in which we see people and the personal resources they need to deal with illness. We have suggested three basic concepts to help move forward in these areas: the Community Resource Base, the Knowledge Resource Base, and the Personal Resource Base.

At its heart, recovery is about people and how they overcome the impacts of mental illness. Consumers describe it in different ways, but common to most accounts is regaining a significant degree of control in one's life and finding a positive sense of self and a meaningful place in the world. The illness loses its central and life-defining position and takes on a more secondary role. Although recovery is a deeply personal process, it is one that must always be seen in a complex social context. Recovery's partners – excellent services and supports, a positive way of understanding and making sense of illness, and the personal base of strength and resilience needed to cope successfully – are an integral part of the picture.

Recovery is not simply an end state, and there is no checklist or scale that can be used to determine if it is permanently in place. The benchmark will always be the experience of consumers, and this experience is produced on an ongoing basis, day by day. Recovery needs to be achieved not once, but over and over again. We all receive a barrage of messages in our daily lives, and many of these shape how we see ourselves. Some messages are implicit and come from our social context – do we live in a nice place, do we work, do we have money to spend – and some are more overt – do people avoid us on the street, do we hear stigmatizing language about a group we belong to, do friends and family value us – but all these messages create a mirror for us.

Three Pillars of Recovery

RECOVERY

Personal Resource Base

Hope

Practical Understanding of the Illness

Positive Sense of Self

Resilience

Being in Control of Your Own Life

Confidence

Purpose & Meaning

Inclusion & Belonging

Well Being

Knowledge Resource Base

Recognition of Diversity

Experiential Knowledge

Customary/ Traditional Knowledge

Social Acceptance & Inclusion

Transforming Our Understanding of Mental Illness

Mental Health Literacy

Social Science Knowledge

Medical/ Clinical Knowledge

An Enriched Range of Services & Supports

Housing

Self Help and Consumer Organizations

Family & Friends

Income

Person

Work

Mental Health Services

Generic Community Services & Groups

Education

Community Resource Base

This mirror and the reflections we see in it shape an important part of our identity. For many consumers there is a turning point on the road to recovery, when someone – a family member, a professional, another consumer – recognizes their potential to transcend the illness and infuses them with this belief. Recovery can only exist when consumers receive affirming and positive images and are able to match these in their sense of themselves.

With the tools, the understanding, and the people we now have working towards recovery, it is time to start writing a new story about people with serious mental illness. The story we usually hear is a sad one, about failure, abandonment, and the "plight of the mentally ill". We hear it over and over, and we need to hear it to the extent that so many people live lives of needless despair in which their gifts and aspirations go unfulfilled. The good news is that a different story, based on recovery, is now being written. Recovery is about success, new challenges met and overcome, and a new and enabling understanding.

We have succeeded in the huge task of imagining recovery, and we have started to build it. Now we will finish the job.