Part II (of a two-part series):

Impact of Managed Care and Continuing Challenges

by

Athena McLean, Ph.D.
Central Michigan University
Department of Sociology, Anthropology, and Social Work
Anspach 128
Mount Pleasant, MI 48859 USA

athena.mclean@cmich.edu
home office: 517-333-3703

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1. The centers targeted for cuts include the National Empowerment Center (NEC) in Lawrence, MA; the National Mental Health Consumers’ Self-Help Clearinghouse, Philadelphia; the Consumer Organization and Networking technical Assistance Center (CONTAC) in Charleston, W VA; The National Consumer Supporter Technical Assistance Center at NAMI, Arlington, VA; and the National Consumer Support Technical Assistance Center of the National Mental Health Association (NMHA) in Alexandria, VA.

Abstract
This article is the second in a two-part series that examines multiple forces that have situated the psychiatric consumer movement today, either propelling it or trying to reverse its achievements in shaping the production of mental health services. Since its anti-psychiatry beginnings, the consumer/survivor movement has succeeded in promoting its self-help recovery perspectives and gaining legal rights for patients. On July 22, 2003, the U. S. President’s Freedom Commission on Mental Health advocated a consumer-driven and recovery-oriented mental health system – a major coup for consumers/survivors. At the same time countervailing forces began blocking their efforts, challenging their accomplishments and promoting opposing agendas. This article examines the impact on consumer initiatives resulting from a restructuring of behavioral health services in the United States under managed care. It also considers the oppositional economic, political and economic forces that have attempted to erode consumer gains in recent years. Last, it examines recommendations of the Freedom Commission, and considers their implications for the future production of mental health services in a political environment where consumers/survivors have recently lost legal ground.

Introduction
This is the second of a two-article series that examines various forces that have situated the psychiatric consumer movement today, supporting and helping to promote its ideas or working to oppose it and to reverse its achievements in shaping the direction of mental health services in the United States. Part I of this series examined how professionals came to embrace consumer/ survivor perspectives as well as the attempts of oppositional forces to de-legitimize its early gains. This part of the series will consider the impact that the restructuring of behavioral health services under managed care in the United States has had on the gains achieved by the consumer movement. It will also review continuing attempts of oppositional forces to erode consumer gains. Finally, it will examine the recommendations of the Freedom Commission on Mental Health Services and consider their implications for the future production of consumer and other mental health services. The recovery emphasis of the recommendations is of particular interest in light of adverse legal decisions that have recently impacted consumers/ survivors under the current political environment.

EMERGENT CONSUMER-DRIVEN PLANS WITH THE RESTRUCTURING OF PUBLIC BEHAVIORAL HEALTH SERVICES UNDER MANAGED CARE.

Since 1965, Medicaid has been a joint program between the federal and state governments to provide fee-for-service health care to the indigent. As states faced rising Medicaid (1) and mental health costs (2), shrinking budgets and increasingly fragmented services (3), they began turning to private sector capitated payments (4, p. 17) and managed care models to contain Medicaid expenditures for their behavioral health services. By the mid-1990s, as they were shifting from fee-for-service, many privatized their services by turning to a for-profit managed behavioral care organization. Instead of reimbursing providers directly, the states contract out services to the private managed care organization that arranges service coverage. To use Medicaid in this
innovative way, states needed to obtain Medicaid waivers in order not to violate the federal government’s requirement for fee-for-service arrangements (2). By now, most states have arrangements with managed behavioral care companies (5), although some have chosen either at the state or local level to manage the care themselves through a non-profit managed care vehicle.

The Lesser of Two Evils?: Consumer Hopes for Managed Care.

For many consumers from Phase Two of my study, described in Part I of this two-part series, the potential limitations of a managed care approach paled when contrasted with the problems of a mental health system they viewed as invasive, coercive and intransigent. Under managed care, they anticipated more consumer choice and provider accountability, and hoped this would shift the power balance from provider to consumer. Also, as control shifts from providers to those interested in the bottom line, consumers expected reforms might lead to reductions in involuntary commitments and less intrusive services that one activist called, "less expensive and less offensive to us." The biggest advantage many saw to managed care, however, was its absence of the "ideological baggage" of the traditional health system.

Because the potential for mental health reform is financially driven, consumers saw in managed care restructuring an opportunity to radically revise the system through their own input (6, p. 210). Many believed that the shift in power away from providers would force the system to change its standard practices. They felt that managed care provided a means of dismantling and radically transforming a mental health system that, despite their years of advocacy, has been recalcitrant to change. With the bottom line -- a different evil -- now dictating delivery of service, consumers overall felt cautious, but more hopeful than they had in the past.

Contrasts Between Managed Care and Consumer Philosophies.

Nonetheless, there are fundamental differences between managed care and consumer ideologies and approaches. The emphasis of consumer organizations on ongoing mutual support as central to recovery contrasts sharply with for-profit managed care organizations’ emphasis on measurable symptom decline (7, p. 14). Managed care organizations favor time-limited standardized models that target concrete behavioral symptoms rather than ongoing community services or programs that address global subjective and interpersonal needs (8). They prefer ‘technologies’ (6, p. 228), which like a pill, help manage concrete behavioral symptoms as "natural" objects, alienated from their social and historical circumstances. Like reductive biomedical approaches, they try to eliminate the sign (the symptom or behavior) rather than improving the subjective experience associated with that sign or the social conditions productive of it (9, pp. 61-74; 10, p. 75). These technologies are consistent with the alienated and discrete service unit approach of managed care. While some technologies engage consumers in behavioral “self-change” assignments under the directions of a therapist, (6, pp. 224, 228-229), their demand for “client compliance” (6, p. 227) contradicts consumer ideals of self-determination and empowerment (11, pp. 341). Ongoing social support to help the person recover, may be too ambitious and unprofitable for managed care to consider.

Consumer Losses Under Managed Care

As for-profit managers took control of financial expenditures in behavioral health care (12, p. 233), drastic cutbacks eliminated services to persons in deep need (13, p. 110). Consistent with the philosophical aspects I outlined above, managed care has limited services only to those deemed “medically necessary” (14) and excluded continuous residential and rehabilitation treatments (15). Persons not committed involuntarily were denied hospitalization, thus enabling access only by force, not choice. Even more alarming, “noncompliant” patients were disenrolled (16, p. 35) and others with heavy service needs were pressured to disenroll by being denied services (17, p. 163). Most plans also failed to meaningfully involve consumers and their families in planning, implementation and oversight (18, p. 18).

A market driven model designed for the private sector compromises government’s responsibility to a vulnerable population in the public sector (16, p. 34). Given their primary obligation to the bottom line, for-profit managed care systems “lack a social commitment” (18, p. 9). Their cost-savings techniques of gate-keeping and utilization review were developed for a private sector where less than 10% of the populations use mental health services. Four to five times as many persons in the public sector than the private sector have psychiatric diagnoses and their problems are more severe (16, p. 165). Applying a model developed to restrict services to the less needy on a seriously needy indigent population is misguided (17, pp.164-5) and raises ethical questions (13, 19).

Backlash and the Turn to Consumerism. A backlash has developed against managed health care out of growing outrage of its failure to deliver on its promises (18, p. 7) and its placing its own priorities above the public good (20, p. 2625 ). Under managed care, fragmentation and existing inequities are only reconfigured (21, p. 85) or widened (22). In the public behavioral health sector, where restrictive practices have endangered the very lives of the indigent population, the outrage is apparent among providers (23), family consumer groups (24), and researchers (25) alike.

Consumer Gains: Three Case Studies Of Model Service Plans

Consumers have benefited from the excesses of managed care and the backlash against it. This has led to their heightened involvement in planning and oversight of state behavioral health services (26, p. 292; 27, pp. 883-5), providers’ requests for training in their perspectives (28) and entire service delivery plans based on their idea of recovery.

Case One: Georgia’s Certified Peer Specialists: Rehabilitation Counselors And System Change Agents. Since 1999 the Georgia Division of Mental Health under a managed care reconfiguration has promoted peer support and recovery in its public behavioral health care provisions (29). It developed the certified consumer peer specialist (CPS) role as a core rehabilitation service billable under Medicaid. Georgia placed muscle behind this approach by requiring this service as a prerequisite for
Pressure to close the centers came from three sources -- E. Fuller Torrey, an earlier opponent of the original demonstration projects, upcoming conservative psychiatrist Sally Satel, and some extremist leaders at the National Alliance for the Mentally Ill and the NAMI-California.

This section draws on considerable material from consumer websites and related links because they are a primary means for communicating and urging action among consumers and they provide an active and continuously updated source of information.

Case Two: Working the Managed Care System to Promote Recovery in Colorado. In Colorado in 1996 the director of a new partnership between a managed behavioral health care company and eight community mental health centers hoped to integrate the principles of recovery (30) and self help into routine care. She chose psychiatric rehabilitation (31) as the tool (32, pp. 25-6) and brought in a consumer leader to implement these principles. By 2001, eight drop in centers and over 18 self help groups were in service. This was accomplished by drastically cutting costly services -- like outpatient commitment and mandatory partial hospitalization, that consumers deemed infantilizing (32), and using the saved dollars to implement changes.

Ironically the capitation of services (where a set number of dollars follow a client, independent of particular services delivered) in a managed care model provided incentives to adopt innovative approaches (15). Prior to capitation, centers promoted services that helped maintain their financial base. Capitation and reinvestment of savings from dropped services gave them the freedom to shift dollars to support the recovery-based system. However, even more dollars would have been available with non-profits.

Case Three: A Philadelphia Self-Managed Care Plan. In 1997 Philadelphia County created its own non-profit managed care organization, Community Behavioral Health (CBH), which contracted directly with providers. Sensitive to the vicissitudes of political change that could lead to shifts in available services, the new behavioral health system was designed to promote stability and innovation (33, p. 87) to survive shifts in political administrations. The program was guided by an unwavering "people-first" philosophy and vision of managed care to promote access to services in the least restrictive setting. The program encourages consumer choice in services, including consumer-run programs (33, p.88) and accountability by providers and administrators to those served (33, p.90). The service system emphasizes a person’s recovery through full participation in treatment and rehabilitation (33, p. 103).

As the new managed care organization expanded from a team of six to 200 employees, the original team tried to safeguard their vision and promote a sense of community and shared purpose (33, pp. 94-5). They also established a Consumer Satisfaction Team (34) consisting of pairs of consumers and family members to oversee service provision. The team made unannounced visits to treatment sites, conducted over 10,000 interviews with recipients of services. This feedback was used to redesign programs according to stated preferences from consumers.

This new system design, devoted to serving consumers themselves, grew out of fervent beliefs by progressive mental health commissioner and strong consumer and family advocates for a consumer-driven system of integrated care. The managed care approach enabled coordination and continuity of care, albeit in a constrained budget that demanded some difficult choices. With information about consumer wants directing the program, and satisfaction and accountability built into a recovery-oriented system, this design provided a convincing model for programs elsewhere.

THREATS TO CONSUMER GAINS

Such dramatic restructuring of behavioral health systems, sensitive to consumer preferences and built on a philosophy of recovery and self-determination, marked a coup for consumers in the mental health system. By December 1999 the Surgeon General’s report on mental health identified consumers as "the critical stakeholders and valued resources in the policy process" (35; 36). Through the continued labors of consumer/ survivor activists and their advocates, the ideals of recovery, self-reliance and empowerment -- as opposed to chronicity, dependence and disenfranchisement -- appeared accessible. Consumers have been partnering productively with mental health professionals and researchers for two decades to promote their own understandings about the kinds of approaches and services they find most beneficial. The Surgeon General sanctioned the "new recovery approach" as being "supported by evidence on rehabilitation and treatment as well as by the personal experiences of consumers" (36). The recent Consumer Issues Subcommittee report of President Bush's New Freedom Commission on Mental Health also calls for a National Recovery Initiative for a "recovery-based continuum of community care" (37).

In the midst of these successes however well-positioned forces have been acting to limit the consumer voice, oppose their civil rights, and censor or ridicule their ideas and those of their supporters. These forces are apparent in the activities of psychiatrist E. Fuller Torrey -- an earlier opponent of the original demonstration projects, upcoming conservative psychiatrist Sally Satel, and some extremist leaders at the National Alliance for the Mentally Ill and the NAMI-California.

This section draws on considerable material from consumer websites and related links because they are a primary means for communicating and urging action among consumers and they provide an active and continuously updated source of information.

Efforts to Terminate Funding National Consumer Technical Assistance Centers that provide information on self-help, advocacy, services and policies and promote consumer’s relationships with professionals. This surprise announcement came shortly before the funding date (38) after funding had been allocated and approved (39). Although Congress ultimately funded the centers, their future remain insecure.

Pressure to close the centers came from three sources -- E. Fuller Torrey, Sally Satel, and individuals in NAMI, bolstered by their
pharmaceutical supporters. Torrey has been a long-time critic of the Center for Mental Health Services for supporting "anti-psychiatric groups and those opposed to assisted treatment" (40) -- a euphemism for "forced treatment" through involuntary outpatient commitment. He specifically objects to funding the National Empowerment Center in Lawrence, MA for supporting "the salaries of anti-psychiatry radicals" who reject the medical model of mental illness and hold out "a false hope" of recovery without medications (41).

Satel, a psychiatrist and fellow at the conservative corporate think tank, the American Enterprise Institute, sees these consumer information centers as promoting the work of anti-psychiatry consumer-survivor groups (42, pp. 48, 61) She argues that governments should stop funding them -- something that can be "reversed overnight" (42, p. 231; 43) - and has placed herself in positions to make this happen. As a chief mental health policy advisor to the Bush administration, she now sits on the influential CMHS National Advisory Council, which holds decision making power over grants. While admitting that funding to consumer centers is modest, she worries that "it is leveraged fairly effectively" (43) and wants to stop its influence.

Andrew Sperling, NAMI's Public Policy Director, also lobbied against funding the consumer centers. According to consumer advocacy organization Support Coalition International, (SCI) (44), Sterling admitted to "inadvertently" issuing a statement on the organization's public website that he was lobbying the Bush administration to "terminate federal funding" for certain "psychiatric survivor organizations" (45). Groups that were viewed as actively challenging the "scientific basis for mental illness and its treatment" were selected. (Interestingly, The National Consumer Supporter Technical Assistance Center at NAMI was among them.) In a letter to the SCI, Sperling clarified that the policy did not come from the NAMI board, but "reflects long-standing concern regarding the activities of several "consumer/survivor" organizations that are funded by the federal CMHS to serve as National Technical Assistance Centers" (44).

The statement was released during a four month interim period between executive directors when Eli Lilly executive Jerry Radke was placed in charge. Radke had also been on loan from Lilly earlier, as part of NAMI's "strategic planning," according to Laurie Flynn, NAMI's outgoing executive director. Eli Lilly paid his salary and also contributed $2.87 million to the organization between 1996 and 1999 - about ¼ of the income it was receiving from the pharmaceutical industry (46). These moneys fund NAMI's Campaign to End Discrimination (47). (See below.)

**Pushing for Forced Treatment (PACT and Involuntary Outpatient Commitment)**

Consumers assert that the $11+ million dollars from this Campaign to End Discrimination funded NAMI's Program of Assertive Community Treatment (PACT) (47). PACT is an outreach program that provides 24 hours/ day, 7 days/ week mobile treatment and support in the community. When PACT was first introduced in Wisconsin over twenty years ago, some consumers and their families appreciated the caring oversight of familiar staff (48); other consumers were so oppressed by it that their only refuge was to cross the state border to "escape." For many consumers today, it conjures up "a kind of mental health police force" (49). Members of a treatment team visit consumers in their home to secure their "medication compliance" by injection or watching them swallow their pills (47). The potential for abuse in shifting from "aggressive" to "coercive" treatment has concerned some mental health professionals (50), as do the profits to pharmaceutical companies that promote coercive models.

Moreover, as a treatment modality, PACT is enforceable by outpatient commitment laws. These laws order court mandated treatment requiring a person "to take the medication needed to control the symptoms" (51, p. 337) or risk inpatient commitment. In 1997, NAMI founded the Treatment Advocacy Center to promote coercive treatment and involuntary commitment; it has succeeded in implementing outpatient commitment laws in at least forty states. Under E. Fuller Torrey, its president, has won many tough battles, most recently in California.

**Censoring or Ridiculing Opposing Ideas**

Torrey and his advocacy group have gained success by sensationalizing and exaggerating the incidence of violence that occurs among unmedicated persons with psychiatric symptoms. Torrey has publicly disseminated an unsubstantiated statistic from a Justice Department study (52) claiming 1000 homicides are committed yearly by mentally ill people. He used the statistic again in a special issue on "Mental Illness and the Law" of The Journal of the NAMI California (53). Dan Weisburd, former editor and publisher of The Journal, investigated and questioned Torrey's statistic in his "Publisher's Note," adding that Torrey admitted it was a "guesstimate" (54). Torrey has been quoted in The New York Times, the Wall Street Journal, The Washington Post, Sixty Minutes, and in the Congressional Record, all of which depended on his expertise. Weisburd objected to Torrey's falsely raising public fears ostensibly for political reasons.

Members of the NAMI California Board of Directors, some of whom were close allies of Torrey, were outraged at Weisburd's comments and paid to have pages of The Journal containing his Publisher's Note glued shut before reaching the readership. They then terminated The Journal, ending its eleven years of operation. Weisburd was censored because he threatened their ultimately successful political fear campaign to enact an outpatient commitment law in California.

The intolerance this group showed for opposing views can be seen in Torrey and Satel. as well. In 1991 Torrey wrote an angry letter to Alan Lesher, the Acting Director of NIMH, denigrating it for "fuzzy thinking" and its "absurd" support of consumer projects that questioned the medical model. More recently, he excoriated CMHS as an agency that "pursues its hippie philosophy and obstructs reform efforts" (40) adding, "among most professionals, it is ridiculed … and widely regarded as more dysfunctional than the individuals it is supposed to serve."

Satel, on her first day on the CMHS Advisory Council, complained that too much time had been devoted to listening to the views of a consumer -- "‘Patient’ is the term I prefer. Maybe that’s what the Council wants, but it’s not what I want" (55). She minimized the value of the person's comments as a user of psychiatric services. Satel then changed the label of "consumer" to
Satel considers the idea of social determination of illness as “one of the most pernicious themes in PC medicine” (42, p. 14), claiming preference instead for “personal responsibility and self-care.” This is ironic given her hostility to a consumer movement which is based on these very principles. Satel confines personal responsibility, however, to a person’s accepting the biomedical model of disease and complying with the doctor’s orders. Her notion does not address the complex social, political, and economic environment to which power inequalities and their denial contribute to the production of illness, nor allows for critical self-reflection and action to address social determinants.

DISCUSSION: IMPLICATIONS OF THE FREEDOM COMMISSION REPORT IN LIGHT OF OPPOSING POLITICAL ANDIDEOLOGICAL VIEWS

The New Freedom Commission On Mental Health And The Call For Recovery in Transforming Mental Health Systems

In its Interim Report to the President, the Freedom Commission on Mental Health states, “the mental health delivery system is fragmented and in disarray…” (56, Executive Summary, p. 4). The final report (July 22, 2003) recommends, “fundamentally transforming how mental health care is delivered in America…” (56, Executive Summary, p. 5). Based on testimony from consumers, mental health professionals and family members, the Commission concludes that “recovery from mental illness is now a real possibility” and recommends switching from a system which “simply manages symptoms and accepts long-term disability” (56, Cover Letter) to a “consumer-centered, recovery-oriented” one (56, Executive Summary, p. 11). The Commission declares that consumers be significantly involved in everything from planning to choosing providers to delivering services (56, Executive Summary, p. 13). Further, following the 1999 Olmstead v. L.C. decision of the United States Supreme Court, the report encourages that services be made available in “communities rather than in institutions” (56, Executive Summary, p. 12).

Variation in Etiology, Treatment and Recovery. The Surgeon General’s 1999 Report on Mental Health (36) identifies the immensely varied etiologies of behavioral disturbance such that “one single factor in isolation -- biological, psychological, or social -- weighs heavily or hardly at all…” (36, Chapter 2). Similarly, the Commission report acknowledges the great variation that occurs in the most promising blends of services and supports for different persons over the life course (56, Executive Summary). Thus the Commission did not provide any singular “model plan,” like the Assertive Community Treatment (ACT) which NAMI considers “the answer” for everyone, but individualized plans built on identified needs and wants of each person. ACT is just one of many possible evidence-based practices (EBP) currently available (56). At the same time, the report also includes potentially beneficial (57) emerging best practices, which, like the consumer demonstration projects, did not have the advantage of adequate research study.

Like etiology and treatment, recovery and variation in consumers’ experiences of it gained high profile in the Surgeon General and Commission reports. The concept of recovery originated with ex-patients (58), was elaborated by others (59, 60, 61, 62), and was developed by researchers (30, 31). The possibility of recovery was revisited by researchers whose longitudinal studies challenged the belief that serious mental disorders were inevitability chronic (63, 64). While recovery for survivors like psychiatrist Daniel Fisher (41) means a final cure, for most persons, it means a satisfying, socially productive life -- with or without symptoms (65, 30). Restoration of functioning or terminating psychotropic medication are not needed for recovery (60). It can be achieved without professional help (30) as it differs from professionally directed rehabilitation (36); the latter, though may help to promote it. And since recovery restores a person’s dignity and self-worth, it appeals to consumers and families advocates alike (66).

Contradictory Forces: Forced Treatment or Recovery?

Where a person lies on the protection (forced treatment)/ freedom (voluntary recovery) continuum depends in large part on that person’s experiences with both mental illness and the mental health system. Some consumers retain the feeling of indignity from forced treatment even if they acknowledge that it benefited them (62). Others find the loss of self-esteem it imposed so injurious that they totally reject any kind of force (58). Still others are convinced that forced treatment saved their life (42, p. 20). Some family members demand forced treatment, others find it objectionable (67) while others blame it for having lost their relative’s trust. Not all NAMI members support its official policies or methods (68). They are split, e.g., on the issue of forced treatment, as in California where five former presidents of NAMI-California wrote a public letter urging members to not join extremists who were using violence to push for forced treatment (69). The danger of extremists like Torrey, Satel, and some NAMI leaders is that they use the public’s fear of a misrepresented violence, and present their own views as those of a unified membership and the most advanced state of knowledge, when they are neither. The Commission in fact recommends an educational campaign to challenge the incorrect perception that mentally ill persons are more violent than the general population (56, Consumer Issues Subcommittee Report).

Conclusion

The Freedom Commission holds out hope that consumers can rebuild the mental health system so it can work for them; this far exceeds expectations of those I interviewed in my studies. In the coming months Charles Currie, a member of the Commission and the Administrator of SAMHSA, will be reviewing the final Commission report and offering an action plan. It is here where political pressures will be applied. The progressive minded Commissioners who drafted the report will face the test of reality as concrete measures to enact it are developed. Contradictory forces have never been greater. Although consumers have gained ideological ground with their recovery vision, opposing forces have made strides in gaining coercive treatment programs and outpatient commitment laws. These same forces tried to end federal funding of major consumer centers, censored corrective reporting that threatened their agenda, and earlier interfered with the demonstration projects. These forces are backed by drug
In contrast, consumer organizations have always been economically disadvantaged. Without the ability to draw dues from a poor consumer base and the lack of (and disinterest in) support from drug companies, they must depend on government funding and remain vulnerable to political whim, as was seen with the five technical assistance centers. Still, their leaders have developed relationships with government and mental health professionals and have convinced them of the fundamental value of the recovery perspective.

But the battle is not over. The Commission's report -- and recovery vision -- will not appeal to everyone. Many, however, like the current NAMI President, support a recovery-oriented approach (70). As a continuous process, recovery will not be achieved through the time-limited interventions that managed care organizations find profitable. It is also not likely to be achieved through the timely taking of medication in the absence of a meaningful and productive life. It is even less likely to be gained through forcing treatment on someone. Recovery is a holistic, if elusive, concept that incorporates multiple physical, social, economic, political, and even spiritual dimensions (71) that may vary from person to person and over time. To the extent that recovery might impede the interests of some groups (e.g., managed care organizations, the pharmacological industry, psychiatry even families) they are likely to challenge it as a principle for restructuring mental health services. Already Marcia Goin, president of the American Psychiatric Association, reserves comment on it, citing instead a biomedically based model (72). Torrey called it harmful for sending a "cruel message" to very impaired people (73); still he asserts that as a distant goal, it is "laudable." And Satel -- whose appointment to the CMHS Advisory Council was approved by Currie -- will be in a position to pass judgment on action plans based on it.

The Commission's report was crafted by some progressive individuals, including Dan Fisher, whose Technical Assistance center was one of five targeted for closure. Sally Satel's power to pass judgment on recommendations Fisher helped construct may seem defeating. However, it may be that recovery, because of its focus on individual transformation, will be a palatable idea. For as Littlewood argues, America is a "psychologized society," which interprets "social power as personal performance, argues for autonomy and self-scrutiny, for consumer choice and therapeutic transformation" (22, pp. 174-5). Thus as long as recovery is focused on transforming the self rather than the system, and as long as it does not directly threaten the biomedical/pharmaceutical industries, it is likely to be viewed as innocuous, if not desirable. Recovery and the community support on which it depends may also seem compatible with the Bush Administration's engagement of voluntary organizations. Indeed the psychiatric consumer self-help movement started precisely this way.

Thus recovery may be a timely idea around which both the left and right may rally. As a seemingly innocent, non-threatening concept, it may gain adequate political support despite some protests from Torrey, Satel and like-minded groups. Moreover, with outpatient commitment laws now in place in most states, any lingering concerns extremists may hold about recovery are likely to be attenuated. Still, recovery and self-help may be less innocent than they seem. By forcing people to examine their lives, their illnesses, and their possible etiologies, a recovery-based system will demand that they closely confront the societal conditions of their existence. To achieve genuine recovery, they will have to address not only their biological vulnerabilities, but also present and past sources of possible oppression -- social (e.g., sexual, gender, racial, familial), political, and economic -- and eventually confront these. Herein lies its transformative potential.

References


A Global Mental Health Group in coordination with the World Health Organization has called for an urgent scaling up of the funding, staffing and coverage of services for mental disorders in all countries, especially in low-income and middle-income countries.[5][6]. According to the Recovery model, services must always support an individual's personal journey of recovery and independence, and a person may or may not need services at any particular time, or at all. Recovering Consumers and a Broken Mental Health System in the United States: Ongoing Challenges for Consumers/ Survivors and the New Freedom Commission on Mental Health. Part I: Legitimization of the Consumer Movement and Obstacles to It. International Journal of Psychosocial Rehabilitation.