

Implementing Recovery-based Care: Tangible Guidance for SMHAs

According to renowned researcher Courtenay Harding, Ph.D., recovery from mental illness has been researched and proven for decades, and she will cite ten studies from all over the globe as evidence (Harding, 2004). The irony is, as Harding will point out, you won't find a section on recovery in the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders. In fact, you won't even find the word in the manual's index. Only a small minority of graduate mental health programs features a recovery focus, and on the administrative side, the topic of recovery is often overlooked, misunderstood, or moved to the back burner in the face of competing priorities.

Without any infrastructure for recovery-based mental health care, it's no wonder that so many administrators and clinicians haven't bought in to what is essentially a basic human right to feel better. In fact, just mentioning the word recovery seems to cause a stir depending on your training, beliefs, and role in the mental health rehabilitation system.

For the purposes of this issue, we will attempt to define 'recovery' so that the following articles have some context for all readers. We'll begin by quoting Ruth Ralph, Ph.D., "Recovery can be defined as a process of learning to approach each day's challenges, overcome our disabilities, learn skills, live independently and contribute to society. This process is supported by those who believe in us and give us hope" (2000).

Augmenting this definition, we cite a description from the President's New Freedom Commission on Mental Health's *Achieving the Promise* report, "The process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms" (2003).

Our addition to these descriptions would be that recovery is also supported by the power of *consumer choice*. (All of these thoughts and ideas are represented in a conceptualization [available on the Web at www.nasmhpd.org], produced by staff of the New York State Office of Mental Health, that attempts to illustrate the ups and downs of a recovery journey in a positive and illuminating light.)

Thanks to the tireless work of recovery advocates and a boost from the rehabilitation language in *Achieving the Promise*, the concept of recovery from serious mental illness remains in the spotlight. However, this ongoing emphasis on an issue that some may feel is too intangible for action also presents practical challenges to state mental health authorities. What exactly is recovery-based care? How do you transform your system to reflect this concept? How do you measure your success?

We hope this NASMHPD/NTAC e-Report, with its preview of measurement tools now in development; its case studies of successful systems and ideas at federal, state and local

levels; a discussion of workforce issues; and resources for more information, will help you implement the vision of the *Achieving the Promise* to the betterment of your systems, administrators, providers, and especially the consumer/survivors whom we serve.

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Overcoming Obstacles to a Recovery-oriented System: The Necessity for State-level Leadership

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I was asked by NASMHPD/NTAC to comment on overcoming the system's barriers to recovery. In other venues my colleagues and I at the Center for Psychiatric Rehabilitation have mentioned the lack of research on recovery outcomes (Anthony, 2001), suggested strategies for improving such research (Anthony, Rogers & Farkas, 2003), identified the components of a recovery oriented system (Anthony, 2000), and described the values underlying recovery programming (Farkas, Gagne, Anthony & Chamberlin, in press).

We've also opined on the threat to recovery oriented system planning inherent in the implementation of evidence-based practices and perfect model replication (O'Brien & Anthony, 2002). Other publications, including this news brief, have focused on these issues and other concerns related to recovery implementation, such as the workforce, funding, legislative support, advocacy, etc. However, if I had to emphasize a variable that is within everyone's control, yet if poorly implemented becomes an impossible obstacle to state wide recovery initiatives, I would have to stress statewide leadership with respect to the implementation of recovery.

In an attempt to examine state mental health policies and practices that promote recovery, Kathy Furlong-Norman and her colleagues at the Boston University Center for Psychiatric Rehabilitation conducted focus groups and implemented a brief survey instrument with selected state mental health commissioners and consumer administrators in state offices of consumer/recipient affairs. She reports that commissioners clearly identified that their leadership as "change agents" and bearers of public policy and values is an important factor in shaping recovery policies and practices. In addition, the data indicated that the commissioners emphasized the importance of carrying the "leadership mantel" with respect to recovery.

Statewide leadership is so fundamental because the vision of recovery is foreign to what has been masquerading as the mental health vision for the last century. Prior to this vision of recovery, the mental health system had no consumer-based vision, i.e. no vision that focused on what the consumer might get out of the system. Prior visions (using the word 'vision' loosely) emphasized the location of the services (institutionalization, deinstitutionalization, community support systems) or the breadth of the services (continuity of care, comprehensive services) but not the outcome for the person receiving the services.

Personally speaking, I have heard people express their goals with phrases such as decent housing, meaningful work, and/or having friends, but I have never heard people mention that their goal was “continuity of care.” If we are serious about the vision of recovery, then the mental health system of the last century—which for the most part was a system characterized by low expectations, control, and no consumer-based vision—must disappear. Massive system changes must occur if the vision of recovery is to become a reality for an ever-increasing number of people with severe mental illnesses. For this very different vision to become reality, brilliant leadership is required.

Over the past decade I have interviewed leaders in the mental health system about the dimensions of leadership. Their responses can be organized around eight fundamental principles (see Table below). Leaders who are guided by these principles can help make the recovery vision come alive. Conversely, leaders not oriented to these principles can become a major obstacle to recovery. I will elaborate on several of these principles with respect to leadership around recovery.

The essence of leadership is to motivate one’s employees to action around a shared vision, in this instance the vision of recovery. A shared organizational vision is like an organizational magnet—it attracts to it only people with special characteristics. The organization can be energized and mobilized by a shared vision of what is possible. The vision of recovery, as opposed to previous non-consumer focused visions, can provide a sense of purpose and meaning to people who work in the mental health system.

The recovery vision paints a credible picture or image of the future. The leader uses it to pull and push the system toward the future. The leader must communicate this vision repeatedly, through the use of stories, metaphors, anecdotes, and quotations. The vision of recovery allows the leader to tell an inspiring story, rather than the previous broken stories of maintenance and deterioration.

In addition, the story of recovery must appeal to people’s reason and emotion. The research periodically summarized by Harding (1994, in press) and the anecdotes of people recovering from severe mental illnesses (e.g., Spaniol & Koehler, 1994) are some of the tools used by leaders to make the recovery story both factual and inspirational.

It is up to the statewide leadership to create a system-wide culture that identifies and tries to operate consistent with key recovery values. Values are the organizational Velcro that binds vision to operations. Leaders must be clear about the values that underlie recovery, and that each major decision they make is guided by those values. Prior to the recovery vision, statewide operations were not typically evaluated by how they affected consensually defined values. Undergirding the vision of recovery are several key values around which consensus has emerged (Farkas, Gagne, Anthony, & Chamberlin, in press). Four of these values are self-determination/choice, full partnership, people first, and growth potential.

When the leaders are making decisions around various system functions (e.g., policy, budgeting, program regulations and funding, human resource development, evaluation strategies) they should consider how each decision is either consistent with or

antagonistic to these recovery values. The leader who anchors her or himself in the recovery values can ensure that system functions must pass through this “value funnel.”

For example, a system mission characterized by the recovery values of self-determination/choice, people first, and growth potential would be: “To assist people to improve their functioning so that they are successful and satisfied in the environment of choice.” A system mission that is unresponsive to all the recovery values might be: “To provide continuous and comprehensive services to mentally ill clients.”

Similarly, a policy consistent with all four recovery values might be: “People will have the opportunities and help necessary to choose and plan for those services they want to promote their recovery.” Conversely, a policy not passing through the recovery funnel might be: “People must be on psychiatric medication in order to access any residential services used by the mentally ill that are funded with state dollars.”

Another positive policy example that is consistent with all the recovery values is: “Any person with a severe mental illness who wants vocational services will receive them.” In contrast, a negative policy example with respect to self-determination/choice and full partnership might be: “People will undergo a specific test battery before being accepted into vocational services.”

A leader makes sure that the system’s major operations, be they clinical or managerial, are supportive of recovery values. A clinical process that values self-determination cannot co-exist with a management process that values obedience and control. It is through the explication of values that the leader shows what is important to the organization, and defines the corridors in which the state organization functions. In a state attempting to make the massive vision shift from forestalling people’s deterioration to promoting people’s recovery, the leader’s vision and corresponding values must be clear, they must evoke passion, and have consensus throughout the organization.

To implement a recovery vision in their respective states, leaders can be guided by the eight principles of leadership from Table 1. Simply put, recovery initiatives will not occur and be embedded within the system without effective statewide leadership. As pointed out by Kouzes & Posner (1995) leadership development is ultimately self-development. Musicians may have their instruments, and engineers may have their computers, and accountants may have their calculators, but leaders only have themselves.

Leaders are the instruments for system change to recovery. Leaders, through their words and actions, fill in the details of the recovery vision. The leaders’ metaphors, the anecdotes, the traditions, the celebrations of recovery successes all serve to elaborate on the vision’s significance. These elaborations make it easier for followers to be attracted to the vision to which leaders are committed.

Fortunately, current leaders can learn to be even better leaders in the implementation of the recovery vision. Good leaders are born and made—being born is the more mysterious part! Leaders can develop by accessing and using information on recovery, i.e. by observing what their colleagues are doing, by reading and attending conferences about

how recovery is being implemented in various states, by examining Web resources on recovery, and by basing their leadership on some or all of the aforementioned eight principles of leadership. This special issue itself becomes a source of leader development.

Yet in the final analysis, leadership remains an art as well as a science. Some of the tools of leadership are not simply the tools of an expanding knowledge base around leadership. Some remain the tools of the self.

The Principles Of Mental Health Leadership

Principle 1. Leaders communicate a shared vision.

Principle 2. Leaders centralize by mission and decentralize by operations.

Principle 3. Leaders create an organizational culture that identifies and tries to live by key values.

Principle 4. Leaders create an organizational structure and culture that empowers their employees.

Principle 5. Leaders use a human technology to translate vision into reality.

Principle 6. Leaders relate constructively to employees.

Principle 7. Leaders access and use information to make change a constant ingredient of their organization.

Principle 8. Leaders build their organization around exemplary performers.

- Excerpted from Anthony, Cohen, Farkas, & Gagne, 2002.

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Federal Perspective: Recovery, Now!

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The introduction of *recovery* into our national mental health dialogue is nothing short of revolutionary. It is now widely accepted as a key national goal of mental health services, yet just a few short years ago, this was clearly not the case. Our public mental health systems were still dominated by state mental hospitals, and consumers were labeled “the chronically mentally ill” (Manderscheid & Henderson, 2004a).

Most of this momentous change has occurred in the past five years; virtually all of it within the past ten. It is a product of the development of very effective consumer and family movements in mental health, as well as increased dialogue with the substance abuse field, where a similar concept of recovery has been regarded as essential for quite some time.

What is recovery? It is a process, sometimes lifelong, through which a consumer achieves independence, self-esteem, and a meaningful life in the community. Recovery can be facilitated by particular features of care and the care system; it can also be inhibited by other features. Hence, we can speak of recovery-oriented planning and recovery-oriented services.

We have learned about the potency of recovery from many persons, including key leaders in our field. Wilma Townsend and Glen Hopkins, from Licking and Knox Counties in Ohio, have taught us about the key role of consumer-directed care and personalized care plans in the recovery process. Neal Adams, M.D., from the California Department of Mental Health, is preparing a text on individualized recovery plans. Mary Ellen Copeland, provider and advocate, is developing a curriculum to train states and others in implementing the Wellness Recovery Action Plan (WRAP). The state of Connecticut has reoriented its entire mental health system toward a recovery model (www.dmhas.state.ct.us/recovery/htm). Jean Campbell, from the Missouri Institute of Mental Health, has eloquently described consumer perception of outcomes (1998).

Ruth Ralph, from the University of Maine, has developed a measurement scale for consumer-perceived recovery as assessed from the point of view of self-agency, self-esteem, and independence. Steve Onken of Columbia University is working with a group of researchers on developing a measure that will reflect the degree to which care is recovery-oriented. In each of these areas, progress has been very rapid. Once these measures are available, they will be implemented through the Mental Health Statistics Improvement Program (MHSIP) Quality Report and the SAMHSA/CMHS Decision Support 2000+ (DS2K+) data standards and information technology system (Manderscheid & Henderson, 2003, 2004b).

The Final Report of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (2003), has undoubtedly accelerated the move toward recovery-oriented consumer- and family-centered care. In setting a direction to develop a recovery-oriented care system, the report calls for comprehensive planning for each state and individualized plans for each consumer as the two bookends within which Comprehensive Local Care Systems need to be developed. To be successful, these local care systems must be based on sound principles (Manderscheid & Hutchings, 2004). Over the next six months, SAMHSA/CMHS will begin implementation of a federal partners action plan to make the vision of recovery a reality at the state, local, and personal levels.

These developments have a long history of incubation at the national level. The ingredients necessary for building recovery-oriented systems (resiliency-oriented systems for children) come from important work carried out in the past. They have been developed and nurtured in the Community Support Program (CSP) and the Child and Adolescent Service System Program (CASSP), operated in the past by the National Institute of Mental Health (NIMH) and SAMHSA/CMHS. Both CSP and CASSP fostered the approach of consumer- and family-centered care. This means that consumers and family members are expected to participate in the design, implementation, and evaluation of care. The criterion of success is consumer employment and a life in the community. This is clearly the heart of recovery- and resiliency-oriented care.

Both NIMH and SAMHSA/CMHS have also supported, in collaboration with the Department of Education, several Rehabilitation Research and Training Centers focused on recovery. The center at the University of Illinois has examined consumer self-determination; the center at Boston University has examined recovery models at the personal, provider, and system levels.

The Institute of Medicine (IOM) (2001) has undertaken an entire series of studies on the quality chasm between current health care practices (including mental health practices), and what could exist if consumer- and family-centered care were to be implemented on a broad scale. Recently, the IOM has undertaken a new study in this series focused explicitly on mental and addictive disorders. This project will be an appropriate vehicle for furthering practical work in the community on the essential linkage between recovery and transformed state, local, and personal care systems.

Simultaneously, the IOM is moving forward to implement the Crossing the Quality Chasm Framework for five key conditions (depression, asthma, diabetes, heart disease, and chronic pain). The essence of this work is the building of comprehensive recovery-oriented local systems, as well as work to bring national entities together to overcome fragmentation. Mental health can learn much from this endeavor. We hope that local recovery communities for consumers of mental health services would become part of this important initiative in the near-term future.

In all of this work, we do not want to forget the important role that information technology can play in forming local recovery communities. For many years, Sylvia Caras has operated a Web site for people who experience mood swings, fear, voices, and visions (www.peoplewho.net). Sister Ann Catherine Veierstahler has developed a Web site that contains personal stories of consumer recovery (www.hopetohealing.com). These stories, related chat rooms, and strategic information that can easily be provided through the Web could all promote critical interpersonal connections and recovery. In addition, Patricia Deegan, Ph.D., has developed a video library on recovery. Clearly, we have only begun to scratch the surface of modern information technology (Manderscheid, 2004).

There is also discussion of a summit on recovery that could be produced by National Association of State Mental Health Program Directors (NASMHPD) and SAMHSA/CMHS. If such an event occurs, it would be a very important continuation of the recovery movement as we organize the national mental health agenda around recovery and begin to transform services to meet this goal.

Indeed, this is a very exciting time to be part of the mental health field!

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WRAP, Peer Support and Recovery: Tools for System Change

By Shery Mead, MSW, and Mary Ellen Copeland, MS, MA

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Not too many years ago, I was Mary Ellen Copeland, manic depressive. Because I had this label my family was told not to expect much of me. I learned not to expect much of myself. I became dependent on the mental health system to maintain, at best, a minimal life style. I avoided thinking about the future; the present was bad enough. I saw myself through a mental health system lens that was confining and oppressive. Now I see myself through a different lens, a lens that is Mary Ellen Copeland, educator, author, mother, wife, woman.

- Mary Ellen Copeland

Even in these days, when recovery, peer support and Wellness Recovery Action Planning (WRAP) are buzz words throughout the mental health system, it is not uncommon in many mental health environments, including peer support, to hear people describe themselves as their label and to see themselves through a “mental illness” lens.

In the past, this label and this lens has meant life-long professional care while expecting periodic episodes of difficult times. Now, in the era of recovery we have come to expect that people with a label can learn coping skills and can learn to manage their “symptoms,” if they are medication compliant. They may even be employed and play some role in the larger community. But when will they become people instead of their label? And when will it be commonly accepted that people who, from time to time, have troubling feelings, thoughts, behaviors, and experiences (this might include everyone), can also have control over their own lives, do the things they want to do, and be the way they want to be?

Recovery in mental health is an exciting concept. Even more exciting is the concept of life change and transformation—not returning to a former way of being, but going forward to create a new, exciting, and rewarding life. The service delivery system can inhibit the process if it continues to see people through the “mental patient lens.” But it can support and enhance this process if it is willing to see people through this new lens.

The “mental patient lens” is the one many of us (who have labels of mental illness) have learned to look through every time we are uncomfortable, have intense feelings or experiences, or difficult relationships. It is a lens that reminds us that our feelings and thoughts are different than other peoples' and that we must take care. We must avoid stress, risk-taking, and challenges, assume others know better than we do, and that there is a medication for everything. Recovery without understanding this lens still only means “symptom” management and becoming more “functional” rather than true recovery and transformation.

“Sarah,” a member of a peer program, has been in the system for many years. She lives on Supplemental Security Income (SSI) income and her housing is contingent on her disability. Sarah is hearing her friends and even the clinical staff talking about recovery... What does that mean? She starts talking to others who say they’ve gotten jobs and gotten their high school equivalency or gone on to college. Her case manager has changed her title to recovery counselor and says that instead of doing a treatment plan they will do a recovery plan. Sarah is going to the peer center more often. But she is beginning to feel uncomfortable. If she “recovers,” where will she live? What if her benefits are taken away? Can she really support herself? One day there is some conflict at the center and she starts feeling a bit overwhelmed. Sarah decides she should call her case manager.

Sarah tells her case manager that her symptoms are really bad. Her case manager asks her if she’s taken her medication and asks if she’s safe. Sarah responds by saying that she’s taken her medication but it doesn’t seem to be working and she is not feeling safe... We know the end of the story.

How could a different response have changed the outcome? What if the case manager said, “Help me understand what it means for you when you say my symptoms are really bad,” or, “What’s going on at the peer center,” and, “Maybe that’s a pretty normal reaction to conflict...” Or even, “So what will you do to feel more comfortable?” Responses such as these could lead to potentially very different conversations and ultimately to much less dire outcomes.

Some of the current thinking in peer support and Wellness Recovery Action Planning has much to teach us about “unlearning the mental patient role.” These forums and environments can openly address roles, relationships, assumptions and worldview. New approaches are teaching people to challenge each other when they become aware of stuck roles and relational dynamics. Instead of responding from an assumption of “I’m fragile or sick,” more and more people are helping each other think differently about their experiences.

Now let’s look at another path for Sarah:

Sarah decides to join a group of peers who are working together developing Wellness Recovery Action Plans. She takes a close look at all the resources and strengths she has—her love of hiking, her interest in photography, her ability to write compelling short stories and to keep things well organized. She uses things like this, including other ideas from members of the group, to build her own Wellness toolbox.

She works with them to develop a list of things she can do every day to stay as well as possible. She thinks about things that are upsetting to her and develops a plan of simple safe things she can do to help herself feel better (things from her Wellness Toolbox) when upsetting things happen. She works with others as they

all develop lists of signs that they are not feeling so well—signs they formerly ignored. Then, she uses her Wellness Toolbox to develop a list of things she could do to help herself feel better when she is not feeling so well. Next the group discusses those times when you are feeling really bad—very anxious and upset, hearing voices, wanting to abuse substances, thinking about self harm. Sarah says that in the past, when she felt this bad, she would call the crisis line and get herself admitted to the hospital. But others encouraged her to look at her Wellness Toolbox and see if there were some things there she could do instead. She decided that if she spent some time talking to a peer, wrote in her journal about how she was feeling, spent some time diverting her attention with a project, or took her dog for a long walk, she could probably get through this hard time.

The group even worked through the process of developing Advanced Directives that included lists of when people want others to assist them, who they would want to do it, what they want them to do, and what others can do to help. She developed, with the support of her peers, a plan so she could stay at home or in the community, even when she was feeling very bad.

As Sarah began using this—her own recovery plan as a guide to living each day—she realized that along with her plan and the support of her peers she could make choices about her life. She could take risks. She could begin to plan for living in her own apartment, going back to school, getting a job that she would enjoy and perhaps even getting into an intimate relationship. She could see herself through a new lens—the lens of a capable and competent woman.

She also realized in working with others that being “uncomfortable” and having difficult feelings is something she could deal with. She didn’t have to call them symptoms of anything. She could be with these feelings for a time and/or use her strengths and resources to get through it.

As you can see in this example, Sara is changing her lens from mental patient to person. You may also notice another contributing factor to this “unlearning” process—the intentional use of non-medical language. Talking, for example, about our “experiences” and “feelings,” instead of our “symptoms,” as we do when we are developing a WRAP, opens us up to a different conversation in which our lived experience can be explored through multiple lenses.

Implications for Mental Health Services

The recovery movement has challenged the way we think about mental illness and even the concept of mental illness. It has helped many people begin to have hopes and dreams—something they had been discouraged from having in the past.

At its core, recovery challenges the stories that we’ve been told about our experiences and what they mean. It opens up the possibility of discussion about how we can work together in ways that really share power, risk, and expertise. It must be a process in which

everyone moves out of old, comfortable roles and begins to talk about mutuality, boundaries, risk, and who gets to define and decide on treatment. For this to happen, everyone involved must challenge his or herself to respond in new ways.

In addition, we need to have inclusive up-front conversations about power and how we perceive power. Although it is nice to say the words “partnership” and “collaboration,” they are empty unless there is some talk about each of our pre-conceived notions and the reality of choice. By speaking directly about who has the power to do what, and what that means in a collaborative relationship, we can establish guidelines and strategies for handling difficult situations and working through potential conflict without coercion.

Finally, if we are to research and evaluate recovery, it is important to understand the cultural shift in mental health. We need to see beyond measuring “how people are doing” and to see beyond getting a job or fewer hospitalizations as meaningful outcomes. Qualitative research that examines people’s stories will help us look at the extent to which relationships, dynamics, and assumptions are changing, and help us to see how they need to change to support recovery and life transformation. We must all hold ourselves truly accountable to meaningful system change, leaving behind the “mental illness lens.” Rather, we must see people as whole human beings who can cope with adversity and determine the course of their own existence.

Focus on the States: Implementing Recovery-based Care from East to West

By Robert Hennessy, Editor

When it comes to mental health, defining *recovery* may seem difficult. Defining *recovery-based care* in public mental health settings may be more difficult. While there are efforts underway across the country to transform mental health systems into environments that foster and encourage consumer recovery, it is challenging to focus on replicable commonalities. Most administrators will tell you that no two systems are alike. Funding streams vary as widely as the treatment methods, and it's always difficult to compare what works for a certain population with what works for another.

However, with the imprimatur of the President's New Freedom Commission on Mental Health's *Achieving the Promise* report, all states are sensing a need to begin or increase efforts to instill recovery-based care into their systems, and they need tangible guidance. Armed with a handful of emerging promising practices, and believing that there is an intrinsic logic to maintaining health systems that actually foster recovery, many states are skipping the "why transform?" part of the discussion, and have started asking "how do we do this?"

"How we do this" is a good question, with seemingly unlimited and sometimes controversial answers. The list of challenges is long and daunting. Many SMHAs are in financial straits; the average commissioner has been on the job for less than four years (with a median of just over 2 years); and the data on what actually constitutes recovery-based care are not yet robust enough to sway the skeptical.

With that said, one of the best ways to see if the water is warm is to observe those who have already plunged into the pool. From the local provider level in Arizona, to the state-wide perspective in Connecticut, the following anecdotal tales are intended to capture the experiences of two disparate mental health provider entities for the purpose of naming core values and methods that have survived the trial-and-error gauntlet of implementing recovery-based care.

A Desert Education

META Services, Inc., a state-funded vendor of Value Options, Inc., in Arizona, has immersed itself in recovery by literally transforming part of their service system into an educational experience for consumers. The result—consumers become students, and as students they *learn* how to recover.

"It's all about role transformation," said META President and CEO Eugene Johnson, CISW. "In this system, the consumers become students, and this helps people jump into recovery because being a student is a valued social role, and being a mental patient is not."

META's Recovery Education Center is a licensed, post-secondary educational institution. With classes on a range of topics including anger management, living with borderline personality disorder, wellness workshops, and community living, META has created an academic environment that continues to maintain its system's therapeutic purpose.

As an example of the scope of this educational effort, for just one of META's classes—a WRAP-based¹, self-help class—the 2003 attendance was 18,600 students, with more than 200 ongoing classes per month in 20 locations, according to Johnson.

Where did META get the faculty, the curriculum, and the physical locations for such an enterprise? Value Options has a series of case management clinics around the area, so the classes are located where people are already receiving services. This space is provided for free to META. And one of the most significant parts of this process, according to Johnson, is that the curriculum was devised with the help of consumers.

Through an arrangement with the local community college, many of the Center's classes are eligible for college credit so that the students are able to achieve an associate's degree. In addition, most of the classes are taught by META-trained peer specialists.

Another aspect that keeps META in tune with recovery-based care is its staff makeup. According to Johnson, approximately half of the vendor's staff is made up of consumer providers—almost 170 people—many of them trained within META's own Peer Specialist training program.

The 70-hour, five-week course, started several years ago with an establishment grant through the Rehabilitation Services Administration, has graduated 500 peer specialists since 2001. The trainees were all existing consumers in the META system. In fact, the only requirements to enroll in the training program are that potential students have to be 1) receiving services in the system, and 2) willing to come to class.

“About 95% of the trainees graduate, and we find employment for about 68% of them,” said Johnson. “When people begin to work, they begin a whole new level of recovery. It has been transformational not just for the students, but for META's [non-consumer] staff members because as people get better, the whole staff has more hope.”

“The other thing that training and hiring peer support specialists does is change our level of accountability right away,” said Johnson. “We had to change how we write about people, what we are saying. We had to get rid of stigmas we weren't even aware of.”

¹ WRAP is an acronym for the Wellness Recovery Action Program, a self-help program developed by Mary Ellen Copeland that teaches individuals who experience psychiatric symptoms, their family members, supporters, and health care professionals how to reduce or eliminate psychiatric symptoms safely, simply, and effectively on a daily basis, and how to get well and stay well. These skills are taught complementary to, and not exclusive of, other treatments, including medication and rehabilitation supports (Campbell & Leaver, 2003).

META has created a variety of other successful programs, including a recovery housing program that recently graduated 104 students out of 120 enrolled, with 90% leasing apartments, and 70% of those renters free of entitlement programs.

However, META's transformation effort did not come without its share of challenges. When peer specialists are inserted into a traditional mental health system, it can ruffle some staff feathers. When META's existing staff were introduced to the first crop of peer specialists, Johnson heard a variety of complaints. Staff were concerned about confidentiality issues, fears about losing their jobs, jealousy, etc. "We had to find ways to acknowledge these fears," said Johnson. "It was kind of like having a new kid brother in the family."

Another issue that surfaced was the awkward possibility of peer staff needing psychiatric crisis services while on the job. "Our position was that we had to have understanding and flexibility," said Johnson. "Most of the people want to receive services from their peers anyway, not the psych staff, so we try to give them the choice, and then we help them get back to work."

"We've also had challenges around issues of ethics and boundaries; this happens whether we hire consumers or non-consumers," said Johnson. "However, the retention rates are pretty much the same with the regular staff. We've hired about 500 peer specialists, and we have terminated only about ten people."

Staff production is also measured by META management, and all staff are accountable. "These peer providers have to hit the same production that other staff do," said Johnson. "It's fee-for-service, and they have to handle their own paperwork. Our software monitors this, and we have business meetings just like anywhere else."

To help peer staff, META has designated team leaders to serve as mentors. "We have a career ladder that people can move up," said Johnson. Positions include recovery specialists, recovery coaches, team leaders, administrative positions, and faculty.

"We always find a way to maintain the 'peerness' of those services," said Johnson. "The credential of what peers bring is who they are. Their lived experience is what their contribution is. We don't want them being clinicians, using clinical jargon. We want them to tell stories. We want them to tell us who they are. We created this peer support role as a unique discipline, and the training just helps people bring their experience into a therapeutic recovery process," said Johnson.

"META Service has been able to create opportunities and environments that empower people to recover, to succeed in accomplishing their goals, and to reconnect to themselves, others, and meaning and purpose in life," said Leslie Schwalbe, deputy director of the Arizona Department of Health Services/Division of Behavioral Health Services. "META has made an outstanding effort in developing a comprehensive system of recovery-oriented services," she said.

System Recovery in the Northeast

“The average age of people who come into our system is about 35 years old,” said Thomas Kirk, Ph.D., commissioner of the Connecticut Department of Mental Health & Addiction Services (DMHAS). “No matter who you are, at 35 years old, you have some kind of a life, for example, most people at 35 have a partner, or a family, maybe a job, a home. But these people who come into our system have a psychological illness so devastating that it knocks them out of their life,” he said. “Our goal is to reunite people with their life.”

Connecticut has traveled down the path of instituting recovery-based care by reinventing their system based on the belief—and the right—to recovery from mental illness. From its executive team leadership and departmental mission, to its hospitals, local settings, and frontline providers, Connecticut has emerged as an example of progress in system transformation.

A few years ago, when Kirk’s term as commissioner was renewed, he and his executive team set a single, overarching strategic goal for the agency: “Developing and maintaining a value-driven, recovery-oriented healthcare system.” While this was by no means the start of recovery efforts in Connecticut, it was a symbol of how simple the basic ideology of recovery can be, even within the context of a business plan.

Kirk explains, “By ‘value-driven,’ I mean the highest quality of care at the most appropriate or realistic cost. When you look at your existing funding, you must ask, ‘Is the cost to be invested going to produce a measurable increase in the effectiveness of the service’s outcome?’” According to Kirk, this is a simple business question, a question that a CEO of a healthcare organization would ask to ensure his/her dollars are being expended in the most effective way. “Why shouldn’t state mental health agencies do the same?” he asked.

Kirk, along with his deputy commissioner Arthur Evans, PhD, and others, traveled across the state with the recovery message to visit as many providers as they could. Evans started to move the message forward by working with small groups of people, utilizing technical assistance resources to teach new outcome measures, as the measures are often different in a recovery system than a traditional system, according to Kirk.

They also entered into partnerships with educational institutions, notably Yale University, to conduct a Recovery Institute. “Yale developed courses for rethinking our services, including teaching motivational interviewing, being more effective at engaging people into care, new recovery principles, etc.,” said Kirk. Approximately 800 people have gone through the recovery institute, according to Kirk.

The DMHAS hosted all-day retreats, inviting the CEOs and senior clinicians from local mental health and substance abuse provider organizations to discuss the nuts and bolts of what it would take to transform the system from the ground level. From suggestions at

these retreats, Kirk and his staff then met with the boards of directors from some of the organizations to share expectations and ideas for the effort.

Using a “Centers of Excellence” program, DMHAS solicited the state’s local providers and settings to have them share their recovery-related success stories. The department then identified local agency programs that featured promising practices in recovery-based cultural competence, peer support services, and effective engagement techniques, among others. The department offered these sites free consultation on sustainability while learning how each program worked. The end result was a two-way exchange of ideas and information that highlighted exemplary programs along the way.

Now, the department uses these Centers of Excellence as models. “Through this effort, we are improving quality across our system, especially highlighting ideas and programs that help support recovery,” said Kirk.

In terms of reimbursement for some of these newer, recovery-based services, Kirk said his staff has worked hard to get federal technical assistance “to help identify service formats that will be more easily reimbursed or identified as eligible for federal entitlement.”

For instance, he cited a behavioral health program for people on general assistance. “It’s a basic needs program, but we were able to use the general assistance dollars to run recovery houses,” said Kirk. “The houses feature 20-bed residential units that a person can come to after inpatient stay for substance abuse or mental health services. They are relatively inexpensive to run, and the state was willing to invest in them for basic needs despite the fact that there’s no treatment. It’s just basic needs to help people move forward: transportation, some months of rent, tools for getting a job,” said Kirk. As long as they are in care, they are eligible for the program, as well as a shot at recovery *in* the community.

Kirk listed many obstacles to implementing recovery-based care, among them providers who mistakenly think they are already providing such care; a deficits-based intake system; the potential liability of consumer treatment choices; and a high commissioner turnover rate. However, Kirk, META’s Gene Johnson, and others interviewed for this Special e-Report feel there are as many effective tools and ideas as there are challenges. Some of those tools and ideas are recapped below.

- Identify the people and organizations in your system that are already working on recovery efforts, highlight them, then build up some friendly peer pressure to inspire others to catch up.
- Utilize peer support services in your clinical programs and consumers in recovery in your administrations. Nobody knows recovery better.
- The dollars put into staff training are a good investment. If possible, make training a necessity, not just a priority.
- Find your system’s “recovery heroes” and get them into the media and use positive media coverage to educate the public about recovery.

- Find a way to sustain services rather than having them be short-lived crisis services. Recovery is a journey, not a quick fix.
- Redo your language—from missions and goals, to forms and everyday paperwork—to reflect non-stigmatizing recovery nomenclature (visit <http://www.uspra.org/pdf/langGuidelines.pdf> for language guidance).
- Consider changing the role of consumers in the system to students, peers, or teachers. Making their role more valued by society is a huge step in helping people recover.
- Understand that this is a long-term project and that there is no single approach to implementing recovery-based care. One of the most important tasks for commissioners is to institutionalize this effort so that it is not driven by an individual person.
- Avoid being heavily ideological. Set “do-able” goals for the first year so you can see gains, then move on from there.
- Show concrete differences in how recovery-based care is provided/delivered, with specific examples of a recovery plan versus a treatment plan.
- Put a structure in place that will help to build the framework for recovery efforts, then get out of the way. The system’s consumers, providers, and other stakeholders will take it over, and you can serve as the effort’s biggest supporter.

“To me a recovery-oriented system helps the person to not only understand what his disorder is, but it also shows him how to manage it while using the tools of recovery,” said Kirk. “The tools can be medication, diet, therapy—any number of things to manage the illness. It is the consumer’s choice, and they have to be part of the journey. It’s not us doing it for them, it’s us doing it with them.”

For more information on META Services, visit www.metaservices.com. For info on the Connecticut Department of Mental Health & Addiction Services, visit www.dmhas.state.ct.us.

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Getting Creative with Recovery Programs

Compiled from a Report by Jennifer Brown

Ms. Brown is director of Training and Communications of On Our Own of Maryland, Inc., a non-profit group funded by state and federal dollars as well as private donations. The actual “Reel to Real” series is funded by the state of Maryland.

On Our Own of Maryland, Inc., has gone Hollywood in its efforts to instill consumers with the belief in recovery. The group, a statewide mental health consumer advocacy and education organization, has created “Reel to Real,” an interactive workshop series that incorporates skills, tools, and action planning in an educational environment.

Using the analogy of filmmaking, the program teaches consumers to develop “creative control”—that is, being the guiding force and decision maker regarding one’s own recovery—and combine this with the paradigm of “creative collaboration” with the other experts they choose to work with.

The first workshop, “Lights: Illuminate the Possibilities,” explores the concepts, belief, and faith that recovery is possible, and indeed achievable. The second workshop, “Camera: Focus on the Possibilities,” looks at seeing the larger picture, bringing the vision of what consumers want for their recovery into focus, and realizing that the control over the process lies with them. The third workshop, “Action: Creating the Possibilities,” focuses on collaborating with others for success.

In the moviemaking community, that may be the lighting designer, the acting coach, or set decorator. In the recovery journey, that may include a therapist, peer support group, psychosocial rehabilitation program, landlord, or family member.

On Our Own developed the effort in response to feedback from focus groups the organization conducted with consumers throughout Maryland in 2003.

Comment cards from the workshops have shown a very positive response from the participants. “[Two things that I learned about myself in today’s workshop are] that I’m the author of my fate and I’m the hero in my life,” a participant wrote. “[The information in this workshop that was most helpful to me is] that I can help myself more than I think I can,” wrote another participant.

For more information about On Our Own of Maryland, Inc., visit www.onourownmd.org

Tools In Development: Measuring Recovery at the Individual, Program, and System Levels

For many SMHA administrators, offering reimbursable programs and services is the only way to maintain a viable mental health organization. This scenario is not always conducive to implementing new methods and services, many of which are not yet considered evidence-based practices. Recovery should be measurable, though, because for SMHAs it's an accountability issue, and there are quantitative and qualitative aspects to it at the individual, program, and system levels. Today's SMHAs need concrete, replicable, measurable services, and therefore many state mental health officials are looking for tools to help quantify recovery-based care.

Despite the reality that research on recovery measurement is in a relatively fledgling state, there are a variety of recovery-themed measurement tools in various stages of development that are being created to help administrators, clinicians, peer providers, and consumers institute recovery-based care into mental health settings. This special report features a sampling of three separate recovery measurement tools—all in development—including descriptions and progress updates written by representatives of the three efforts.

Ruth Ralph, Ph.D., offers a report on the effort to create a personal measure of recovery within the Recovery Measurement Tool and the Recovery Model. Priscilla Ridgway provides an update on the Recovery Enhancing Environment Measure, which is intended to assess the recovery orientation of mental health programs, and Steve Onken, Ph.D. offers a look at a system-wide tool, the Recovery Oriented System Indicators (ROSI) Measure.

Editor's note: This is not an exclusive list of measures, as there are other measures for recovery in use and/or in development across the country. NASMHPD/NTAC does not necessarily endorse the aforementioned three measures over any others.

At the Individual Level: A Personal Measure of Recovery

By Ruth O. Ralph, Ph.D.

Dr. Ralph, a retired senior research associate with the Edmund S. Muskie School of Public Service at the University of Southern Maine, is a consumer researcher who has conducted mental health research and evaluation for over 25 years.

The Recovery Measurement Tool (RMT) is based upon The Recovery Advisory Group Recovery Model (Ralph & The Recovery Advisory Group, 1999). It is important to review this model in order to understand the background of the RMT.

When the Recovery Advisory Group² was formed in 1999, monthly teleconferences were held to discuss recovery issues. The discussions were based on the considerable experience of the group's members and exchange and discourse of readings about recovery, both published and unpublished. It was the hope of the group's CMHS funders that these discussions would lead to measurement of recovery.

However, the group focused on definition(s) of recovery, and realized that there needed to be a visual way of portraying recovery. Thus, The Recovery Model was developed, discussed, and revised until members of the group felt it truly portrayed a viable description of recovery.

There are several parts to the model [all parts of the Recovery Model are available on the Web at http://www.nasmhpd.org/spec_e-report_fall04measures.cfm]. The first shows a series of ovals to portray the stages one goes through on the way to recovery. These are shown as: anguish, awakening, insight, action plan, determination to be well, and well-being/recovery. The progress through these stages is not linear, but involves considerable moving back and forth, from one stage to another, and possibly backward when things aren't going well. The ovals are arranged in a beginning spiral, to show that one can move through the spiral, and possibly start again, but maybe on a higher plane.

The second part of the model is a grid that shows these stages across the top, with internal and external domains down the left side. In the model, each "box" has a statement that describes recovery at that point in the journey. This grid became an important component in the development of the Recovery Measurement Tool. The third part of the model shows both negative and positive external influences on a person who is working on recovery. The fourth part summarizes the model by placing the person who is going through the stages in the center (represented by a circle) surrounded by both negative and positive external influences. This part is called "The Big Picture."

The development of The Recovery Measurement Tool (RMT) was funded by the Center for the Study of Public Issues in Mental Health located in New York State. A group of consumers from Maine met and reviewed the Recovery Model, with special attention given to the grid with the descriptive statements about the stages of recovery. Using the grid, we developed one or more items for each of the intersecting boxes in the grid. For example, the item "There is hope for me even when I do not feel well," is in the Insight/Emotional box. The item "I visit a number of places to see where I can make friends," is in the Determined Commitment/Activities box.

The result, over a number of meetings, was the development of 100 items. While we worked on this project, we read and discussed information about how to write items—

² The Recovery Advisory Group consisted of the following consumer leaders: Jean Campbell, Ph.D., Sylvia Caras, Ph.D., Jeanne Dumont, Ph.D., Dan Fisher, M.D., Ph.D., J.Rock Johnson, J.D., Carrie Kaufmann, Ph.D., Kathryn Kidder, M.A., Ed Knight, Ph.D., Ann Loder, Darby Penny, Ruth Ralph, Ph.D., Jean Risman, Wilma Townsend, and Laura Van Tosh.

how they should have only one idea, and how they should be clearly written so that they could be understood easily.

We also learned about research issues, and how to “test a test.” We came together as strangers, but through this learning experience we bonded as co-workers and friends. We found that while we came from different backgrounds and had different experiences, “our feelings were the same, and we learned about ways to express them in order that others might also be able to express theirs” (Kidder, 2001).

In selecting a response set for these items, we reviewed a number of different types. However, because we wanted this to be a personal measure of recovery, we decided to make the responses range from “not at all like me,” through “not very much like me,” and “somewhat like me” to “quite a bit like me” and “very much like me.” We also included a column of “not applicable.” A thorough review of the items revealed nine items that were duplicates or near duplicates of other items, so they were deleted. The result is a total of 91 items.

Items were randomly arranged with the response format placed at the right of each item. Some information about demographics, e.g., age, sex, education, race/ethnicity, and location were added. This instrument has not been tested with any group at this time. It is hoped that this can be done soon, and a shorter, valid instrument can be constructed from the results.

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At the Program Level: The Recovery Enhancing Environment Measure

By Priscilla Ridgway, M.S.W.

Ms. Ridgway consults with mental health agencies and is a doctoral student at the University of Kansas (KU), School of Social Welfare.

Introduction and Purpose of the Measure

Increasing importance is being placed on moving mental health systems toward a recovery orientation. The need to shift the driving focus of service delivery is evident in strong recommendations made by the Surgeon General (US DHHS, 1999) and the President's New Freedom Commission on Mental Health (2003). Given the call for such profound change, mental health administrators across the country are asking questions such as: What services and supports are important in a recovery-oriented mental health system? What recovery-facilitating practices are currently underdeveloped in our system? Where are the people we serve on their journey of recovery? How well are we facilitating people's potential for resilience and recovery? The Recovery Enhancing Environment measure (REE) was designed to provide empirical answers to such pressing concerns.

Developing and Testing the REE Measure

REE was created in 1999. The content of the measure was developed based on: 1) an examination of first person accounts of the process of mental health recovery and the services and supports people say enhance their recovery; 2) a review of emerging promising practices that promote recovery drawn from informal literature, workshop descriptions, and progressive programs; and, 3) a literature review of factors that facilitate resilience, or that help people rebound from adversity, in general.

The REE measure was reviewed and pre-tested by Kansans involved in a Consumer-as-Provider training program, and later by persons served by a day treatment program. Items were revised, dropped, and added based on consumer input. The measure underwent technical edits and the format was refined based on the input of colleagues Allan Press and Patricia E. Deegan.

Two formal pilot tests were conducted on the REE. In 2002, the Kansas Department of Social and Rehabilitation Services funded a mail survey of those served in the seven largest community support programs in the state. It was conducted by the Kansas University Office of Mental Health Research and Training in collaboration with participating community mental health centers (Ridgway, Press, Ratzlaff, Davidson, & Rapp, 2003). More recently, Pat Deegan & Associates trained a cadre of mental health consumers to gather REE data in face-to-face interviews with nearly half of those served by a large Massachusetts mental health agency (Ridgway, Press, Anderson, & Deegan, in preparation). More than 500 people completed the REE in the two pilots. Preliminary statistical analyses indicate that the instrument is psychometrically sound.

Content of the Measure

The REE instrument examines personal recovery by looking at the respondent's self-perceived stage of recovery and the markers of recovery (intermediate outcomes) they currently experience. Respondents rate the degree to which 24 elements are important to their personal recovery to increase our understanding of the process, using a 5 point scale ranging from "strongly agree" to "strongly disagree." These elements include hope, being able to manage symptoms, overall health and wellness, having one's rights respected, being involved in and a part of the larger community, having meaningful activities,

taking on normal social roles, having positive relationships, identifying and building on personal strengths, having one's basic needs met, self-help and peer support, and others.

In order to assess the recovery orientation of the agency, people rate the current status of three specific staff behaviors or services that support each recovery element. Consumer perceptions are also gathered on the importance and existence of qualities of the service environment that have been found to enhance the potential for resilience. These include the presence of caring and compassionate helpers; opportunities for meaningful participation and contribution; being connected to others in positive ways; and feeling valued, respected, and powerful, among others. The degree to which the agency meets the perceived needs of people on dual journeys of recovery (those who experience dual diagnoses, trauma survivors), those from minority cultural backgrounds and sexual orientations, and recipients who are parents is also examined.

Findings

The findings of the pilots show that mental health recovery is a multi-dimensional process. People are able to place themselves within a particular stage of recovery. Most people are in an active phase of recovery, but many are not yet in recovery, a few experience setbacks, and some view themselves as fully recovered, but having to maintain their gains. Many respondents have one or more special needs. Almost all people can identify at least a few indicators of recovery in their lives, and many are able to claim several markers of personal recovery. These markers include being involved in productive activities, having trusted people to turn to for help, having goals one is working to achieve, controlling important decisions, feeling hopeful about the future, having one's symptoms under control, working, having a sense of belonging, and several others. These markers have performed well as a measure of change over time in other research. People gain ground concurrent with, or in part due to, exposure to recovery-enhancing programming.

REE begins to define a complex set of activities that enhance the potential for recovery from the perspective of service recipients. Consumers were able to differentiate higher performing programs from lower performing programs on the basis of statistically significant differences in the mean rating of program performance, as well as significant differences within and among programs along specific dimensions of practice.

Listening to the Voice of Lived Experience

The REE includes open-ended questions that ask people about the lessons they have learned in their own recovery and that give advice to staff and to others just starting out on a journey of recovery. These data were analyzed by themes. A few quotes give the flavor of the wisdom people generously shared.

“Never give up on you. Keep your head up. Everyone else might give up, but don't give up on you, because if you do, there is nothing else to live for. Do the best you can do every day. Never quit. Don't say I can't. Can't never

did anything.”

“Don’t go it alone. We are survivors, and although the trip is hard, it is well worth the wealth of knowledge, understanding and the happiness you will be able to regain.”

“You will need a philosophy. I have one for you. It is four words, all action verbs: work, play, rest, love (what you can).”

Discussion

The REE allows programs to gather data from the recipients of services to assess gaps in important dimensions of recovery-enhancing programming, and to understand the needs of those who have not yet begun to recover or to experience recovery outcomes. In the spirit of appreciative inquiry, REE data can also be used to identify and celebrate positive elements of the program that are already in place that support people in their recovery, and the progress and wisdom of participants who are already moving forward in recovery.

Data from the REE can be used to plan recovery interventions, retrain staff, and target program innovations. The measure is intended to serve as a useful tool in processes of strategic planning that involve consumers, staff and administrators in point-in-time or on-going agency self-assessment or program evaluation efforts.

REE requires a significant investment of time and resources, but these are well spent if the data are used to identify priorities for program development and to set specific targets for transforming mental health agencies, thereby enhancing the potential for recovery among people using mental health services. REE is one of several tools that can help the field move toward fulfilling the vision that all mental health systems assume a recovery orientation, and that recovery is possible for everyone.

The REE measure is complete and in a scantrons (computer read) format. Permission to use the measure and ordering information are available from PRidgway@ku.edu. A brief user’s guide, an MS Word version of the measure, a booklet summarizing the wisdom of people in recovery, and reports on the pilots should be available as of September 2004, from the Office of Mental Health Research and Training, University of Kansas, School of Social Welfare, Lawrence KS, 66045.

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At the System Level: Consumer Self-Report Survey and Administrative-Data Profile

By Steven J. Onken, Ph.D., representing his fellow researcher team members Jeanne M. Dumont, Ph.D., Priscilla Ridgway, M.S.W., Douglas H. Dornan, M.S., and Ruth O. Ralph, Ph.D.

Dr. Onken is an assistant professor at the Columbia University School of Social Work and a co-principal investigator of the Mental Health Recovery: What Helps and What Hinders? National Research Project.

The Recovery Oriented System Indicators (ROSI) Measure is the product of the *Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators* effort. This research project evolved from collaborative efforts among a team of consumer and non-consumer researchers, state mental health authorities³ (SMHAs), and a consortium of sponsors⁴ working to operationalize a set of mental health system performance indicators for mental health recovery.

³ AZ Dept of Health Services Div of Behavioral Health Services, CO Mental Health Services, NY State Office of Mental Health, OK Dept of Mental Health & Substance Abuse Services, RI Dept of Mental Health/Mental Retardation, SC Dept of Mental Health, TX Dept of Mental Health & Mental Retardation, University of HI-Manoa Adult Mental Health Div, UT Div of Mental Health, WA Dept of Social & Health Services Mental Health Div.

⁴ Center for Mental Health Services, CO Mental Health Services, Columbia University Center for the Study of Social Work Practice, Human Services Research Institute, Mental Health Empowerment Project, MO Institute of Mental Health, Nathan Kline Institute Center for Study of Issues in Public Mental Health, National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning, & NASMHPD Research Institute, Inc., NY State Office of Mental Health, OK Dept of Mental Health and Substance Abuse Services.

Conceptualized and directed by a five-member research team (the majority of whom are primary consumers) as a three-phase process (i.e. grounded theory inquiry concerning the phenomenon of recovery; creation of prototype systems-level performance indicators; and large-scale pilot testing), Phase One and Two have been completed. This briefing summarizes the research process and resulting ROSI measure.

Phase One involved a grounded theory, multi-site qualitative design to identify the person-in-environment factors that help or hinder recovery for people experiencing severe and persistent mental illness. Nine SMHAs used purposive sampling to recruit 115 consumers that participated in 10 structured focus groups. Researchers used rigorous, constant and comparative analytic methods involving qualitative coding, codebook development, cross coding and recoding of the focus group transcripts to develop a single set of findings. All nine SMHAs conducted member checks with focus group participants regarding the coding report for their respective focus group. The research achieved a “confirmability index” (agreement that the coding captured the original content) of 99.47% among the 59 who responded (51% of the original sample).

A conceptual paradigm for organizing and interpreting the phenomenon of mental health recovery emerged from the findings. While recovery is a deeply personal journey, there are many commonalities in people’s experiences. Recovery is facilitated or impeded through the dynamic interplay of many forces that are complex, synergistic, and linked. Recovery is a product of dynamic interaction among characteristics of the individual (self-agency, holism, hope, a sense of meaning and purpose), characteristics of the environment (basic material resources, social relationships, meaningful activities, peer support, formal services and staff), and the characteristics of the exchange (hope, choice, empowerment, referent power, independence, interdependence). Each of these emergent domains/themes contain a rich and complex network of helping and hindering elements.

In Phase Two, the research team used these findings to develop recovery oriented performance indicators. Two sets emerged, 73 consumer self-report data items and 30 administrative data items. In partnership with the participating states, the team refined the self-report set based on consumer review (a Think Aloud process) and a readability check and then conducted a prototype indicator test involving a diverse cross-section of 219 consumer/survivors in seven states. The research team then used the prototype self-report data results to evaluate each item as to: (a) importance rating, (b) factor loading values within a varimax rotated component matrix, (c) response scale distribution and direction, (d) Phase One originating theme, (e) items assessing similar content, (e) clarity of wording, and (f) Phase One member check priorities. Selected demographic variables (e.g., housing status; parent status, etc.) were also cross-tabbed with selected item importance mean ratings to determine whether significant differences exist and therefore if an item should be retained or specified for a particular subpopulation.

The research team generated specific measure definitions (i.e. numerators and denominators) for the administrative data items. The 10 participating SMHAs and the National Association of Consumer/Survivor Mental Health Administrators

(NAC/SMHA) were then surveyed on the administrative data items as to (a) the feasibility of implementing each, (b) the importance of each for improving system recovery orientation, (c) whether or not the data articulated in the definition was currently being collected, and (d) specific comments on each. Nine SMHAs and three NAC/SMHA members responded. Through a series of teleconferences the research team evaluated each measure as to importance rating, feasibility rating and comments.

These analyses led to further refinement with a concentrated effort towards parsimony, resulting in 42 self-report items being crafted into an adult consumer self-report survey, and 23 administrative-data items into an authority/provider profile for the Recovery Oriented System Indicators (ROSI) measure. A factor analysis of the 42 self-report items resulted in domains of Person-Center Decision-Making & Choice, Invalidated Personhood, Self-Care & Wellness, Basic Life Resources, Meaningful Activities & Roles, Peer Advocacy, Staff Treatment Knowledge, and Access. The 23 administrative-data items also include the domains of Peer Support, Staffing Ratios, Consumer Inclusion in Governance, and Coercion.

The ROSI bridges the gap between the principles of recovery and self-help—choice, hope, purpose, relationships, self-determination, empowerment, citizenship, resources, opportunities—and the real-world application of these principles in the everyday work of staff and service systems. The ROSI is targeted for large-scale pilot testing. A subset of these items are being incorporated into the Mental Health Statistics Improvement Program Quality Report Version 2.0, the Decision Support 2000+ and other national data collection requirements in order to generate comparable data across state and local mental health systems.

For further information: The Phase One Technical Report, a.k.a. Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators, is available through NTAC at www.nasmhpd.org/publications.cfm#techreports The Phase Two Technical Report is being written and NTAC hopes to release this by the end of the calendar year. If you are interested in serving as a site for the pilot test, please contact Steven Onken at so280@columbia.edu

Expert Panel Discusses Workforce Issues in the Face of a Recovery-Based Care Transformation

By all accounts, system transformation requires a skilled and dedicated workforce that is willing to be flexible while enabling change. For state mental health agency administrators, the workforce provides both a source of daily challenges, and the answers to the system's ills. Whether consumer or non-consumer, psychiatrist or nurse, the workforce is the engine that makes the current system run. This NASMHPD/NTAC e-Report features a panel of three experts on recovery-based care issues discussing the status of a public mental health workforce on the verge of system transformation.

Patricia E. Deegan, PhD, of the consulting firm Pat Deegan & Associates, also serves as a senior program advisor with Advocates for Human Potential, Inc. Mary E. Jensen, RODC, MA, BSN, is a development specialist for Consumer and Family Services for Illinois DHS/DMH-Greater Illinois North Region. Edward L. Knight, PhD, CPRP, is the vice president of Recovery, Rehabilitation, and Mutual Support at Value Options, and is also an adjunct professor of Rehabilitation Sciences at Boston University.

1) What can the public mental health system workforce (clinical and administrative) do to become more informed about recovery-based care?

Deegan: I think the number one thing is to listen to consumer/survivor/ex-patients in the mental health system about what helps and what hinders recovery. We need to urge staff to get beyond the assumption that people with psychiatric disabilities can't speak on their own behalf. Pay attention to people who work as advocates, especially those with first-hand experience of the system. Include consumer/survivor advocates at all levels of the mental health system to make sure that we are there in a real presence, represented in all our diversity. There is an error that is often made that we all think the same way, that if you have one consumer on the committee, that makes it an integrated committee. Also, don't just listen to satisfaction questionnaires. These can be misleading because what the survey shows is a person's level of satisfaction with the services, as if the services themselves are an end point. One of the keys to understanding recovery is that services should be a means to an end—living a full and meaningful life in the community, with relationships enmeshed with the world of commerce, employment, and education. To me, rehabilitation is about services, technologies, professionals, advisors, or experts that people with psychiatric disabilities can consult with, can receive guidance from, can involve themselves with about shared decision making. Recovery is a person-centered phenomenon. You can't 'do recovery' to someone. You can't 'do services' that will force someone to recover. Recovery-based services will always be one small part or one small ingredient for a person with psychiatric disabilities to achieve a meaningful life in the community.

Jensen: In terms of ideas I have heard from the field, one idea is to make it mandatory that all current and new professionals take some sort of psychosocial rehabilitation certification course so that they know about rehabilitation. Another idea is to promote

self-education. What is recovery? What is recovery-based care? Start this process by inviting people into hospitals and clinics to tell their own recovery stories as people with lived experience, and to convey what works and doesn't work. Another way would be to host short, on-site, mini-recovery conferences on topics selected by persons with lived experience: patients, clients, consumers. Another idea is to become involved through their local peer-review board, in order to connect their local board to efforts such as the Annapolis Coalition on Behavioral Health Workforce Competencies and their efforts. A sub-item on that would be to support the efforts of coalition groups such as the Annapolis group to develop across discipline and across provider competencies in order to ensure that recovery-based services are being delivered. Another way is to apply for federal, state, or private grants to provide recovery-based education and program development.

Knigh: There are four rehabilitation or recovery packages for the workforce. I agree with Pat Deegan that recovery is the lived experience of rehabilitation. I think that the skills training approach and the strength-based approach are what's needed, rather than the "psychology of adjustment" approach. The psychology of adjustment attempts to adjust *you* to a baseline that is usually your lowest functioning level with a mental illness. Everything else you attempt to do is seen as delusional. A psychology of respect would be based on strengths and teaching skills, rather than trying to adjust you to your mental illness. The packages are 1) from University of Kansas – a strengths-based case management approach, which has recently been thoroughly updated by Priscilla Ridgway in a book called *Pathways to Recovery*; 2) Bob Lieberman of UCLA [the Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation] has a set of skills packages that is very good; 3) Eli Lily has the Team Solutions rehabilitation package [in conjunction with the University of Medicine and Dentistry of New Jersey (UMDNJ)]; and of course there is 4) the Boston University technology—probably the most extensive of the technologies. They recently came out with a package of 68 skills [*Practitioner Tools for Achieving Valued Roles (Compendium Version)*] that can help people regain the skills they've lost during institutionalization, either in the community or in the hospital. Institutionalization "de-skills" people. It's a result of being institutionalized and having things done for you, and being repeatedly told that you have to adjust to a situation where you can't expect anything out of life, a.k.a. the psychology of adjustment. You can't expect to have normal social relationships, jobs, or a car. These four rehabilitation packages are all out, they are available for purchase, and you can get some training on them.

2) Can you provide some detail on how consumer/survivors can help mental health professionals facilitate the system's transformation to recovery-based care?

Deegan: Nothing about us without us. We want to be involved at every level of decision making, we don't want to be just relegated to an advisory board. Also, we want to be represented in large enough numbers that reflect the diversity of opinion within our community. Systems need to work with consumers to see how health systems can support resilience in all consumer/survivors rather than treating deficits. The workforce should learn that persons with disabilities do not have special needs. I have the same needs as you. My needs are for community, companionship, decent, affordable housing, the right

to say what I want to do with my life, and the resources I need to achieve that end. When my needs are converted into special needs, then somehow it becomes the prerogative of specialists to address my special needs. Then we are talking about specialized placement. I don't want to live out my life in the netherworld of 'human service land.' I want to live out my life in the real world with all of the stress and struggles and the wonder and complexity of it all. We've got to get off organizing models of service and instead start talking about supports for living real life. I think consumers can provide an enormous help because I don't believe that systems can care. Some systems throw up roadblocks and impediments to recovery. There are also marvelous models of innovation in person-centered recovery that show us how to get rid of those obstacles so we actually have support. In a transformed system, it will be the establishment of our humanity as a common ground from which all work and all care can possibly emerge.

Jensen: Consumer/survivors can help mental health professionals facilitate the transformation in several ways. From my informal survey of consumers, they say that if consumers could be volunteers in state hospitals, working with the patients on recovery issues, then the staff would be able to see positive changes. Additional ideas would be to become partners with academics, professionals, researchers, and mental health service organizations in order to co-develop, co-lead, and co-author efforts. An example of this from Illinois would be the Recovery Assessment Scale. This scale looked at perception of recovery from the service user's point of view. It was a partnered effort by researchers, administrators, and mental health consumers. Other ways would be for consumers to seek inclusion on boards of mental health service organizations, local chambers of commerce, church boards, library boards, etc. to promote education in the area of mental health recovery. Another way is to seek to learn and lead recovery education groups, such as Mary Ellen Copeland's Wellness Recovery Action Plan [WRAP], and try to change the culture from within. Another idea is to use that same WRAP approach through organization development, and this could be also be co-lead by people with lived experience and organizational experience. Another idea is to create groups to provide services to peers. This could be a non-profit group for educating, or it could be a support group, transportation assistance, companionship – there are all kinds of ways to develop peer services. Also by providing peer crisis services, and peer hostel services, peer hospice services, or peer support services. The next item would be to learn how to break the silence, which Pat Deegan talks about, whenever disrespect occurs, to come to the aid of people who need it rather than being silent. People can influence micro-aggression [*Editor's note: see Deegan's answer under #3*] right where services are being delivered. Consumers can learn how to break the silence about macro-problems in this micro way. They can break the silence about how restraint and seclusion occur.

Knight: I think that receiving a serious mental health diagnosis is what Andrew Phelps calls, a "social death sentence." I think the workforce should listen to consumers very carefully so consumers can present the social death sentences they've received, and also present what's been helpful in overcoming these sentences and regaining meaning and purpose. We as consumer/survivors have kept recovery on the agenda, and our political clout has been great, enough to keep it on the agenda. There have been a number of attempts to move recovery from the agenda, including the narrowly defined evidence-

based practice movement. I emphasize *narrowly defined* if you actually look at the evidence. RAND Corporation did a review and found one best practice—ACT teams. I don't think most ACT teams are recovery-oriented, they are maintenance-oriented, although I do know of some examples where ACT teams use a recovery approach. I think a much broader definition of evidence-based practice needs to be created, and if you use this [broader] definition, than self-help becomes a best-practice. It doesn't have a number of random assignment studies behind it, but then neither do other best practices that are being promoted. I think that the consumer/survivor movement needs to keep up the political pressure to keep recovery on the agenda.

3) What can academia do to instill the philosophy of recovery into the next generation of mental health professionals?

Deegan: I believe that we need to be extremely conscious of language. I did a brief survey of staff and clients from a very typical mental health service setting. I asked for examples of times when you heard someone who was being disrespected, or a time when you were being respected. These weren't evil staff and they weren't particularly awful clients. They were just typical. Their answers included words and phrases like: crazy, nut, psycho, retarded, whacko, nutjob, stupid, sick, creepy, screwy, back-to-the-nut-house, child, drama queen, time-for-the-rubber-room, lazy, get-a-life, substance abuser, loser, for-a-schitzo-you're-doing-very-well, my-taxes-pay-for-your-SSI, [etc.]. These are just some examples of micro-aggression. This is the kind of stuff that is going on daily in programs. Over time, this begins to wear down people and their hope. It creates a culture of hopelessness and despair. In terms of educating people on language and other aspects, we need to begin to operationalize the recovery-based approaches. We need to come down from the principles and talk concretely about personal choice. We need to rethink professional boundaries. We need to rethink approaches to psychiatric medications. We need to create opportunities for mental health workers and students in the profession to have a 'disability internship,' to live in an SRO on \$562 month, using day treatment, using public transportation in rural settings. And this is not to impose any suffering on these students, but to let them feel how profoundly disabling poverty is when there is no way out.

Jensen: From the consumer input I have heard, we need to start in the junior high schools, before people even get into professional schools with educational efforts. As a recent grad of an MSW program told me, consumers should come and speak and tell recovery stories. They could discuss what is good and not good about the existing system's services. Other ideas include having persons with lived experience lead discussions, and to have required courses in recovery competencies. Another idea is to have academics who are also in clinical practice to educate themselves. The concept of recovery is so foreign to how today's professionals are educated, except for a few isolated departments, that it's very hard to find information on recovery. It's more than instilling the philosophy; it's teaching research-based and recovery-based best practice models in the core curriculum. Things such as strength-based approaches to depression, such as case management, or therapy, or professional conduct between physicians and

patients. Another example of a model is implementing WRAP as a model of co-collaboration between patients and providers.

Knight: The field of psychology generally teaches a “psychology of respect” for people without problems and for people with minor problems such as mild depression, and it teaches a “psychology of adjustment” for [people with SMI]. The field of psychiatry is the same. Although, at the University of Colorado Medical School, I get invited in to talk about recovery. Other consumer/survivors have told me that some universities invite them in to talk as well. Judith Cook and the University of Illinois, Boston University, UCLA, University of Kansas – they all have some recovery orientation. One of the most important things to do is to look at the evidence on recovery from schizophrenia that Courtenay Harding has put together. Look at her body of work; look at the work around recovery from bipolar illness. Some of these studies of longer than 12 years show a 75%-or-better recovery rate. From that body of evidence, you can develop a platform from which to begin to approach recovery. The next most important thing is for universities to invite in their local consumer/survivors to speak about recovery. They are eloquent about discussing what hinders and helps their own recovery. Next, universities should hire some staff from the four or five institutions that are teaching recovery to be on their faculty. They can also improve the research agenda at universities, which flows from NIH and NIMH. They are not very open to recovery studies themselves. We have a series of article we’ve written on a research grant and the methodology is excellent. It’s top-notch research, and we are having trouble finding journals to accept our articles that are oriented toward consumer issues. The fact that NIMH almost always does research based on diagnosis, rather cross-diagnosis research, is not very helpful for recovery. Most research done on mutual support and cross-diagnosis, such as Double Trouble and Recovery, has been studied by the National Institute of Drug Abuse. This all relates to academia, and the flow of ideas has to follow the flow of money. As long as NIMH has their priorities where they are, you won’t see much inroad into academia for recovery research.

4) What are the two largest workforce-related obstacles to implementing Recovery-based care in existing systems and settings, and how can they be addressed?

Deegan: The creation of service models, and the organizing of services around models, as opposed to encouraging individualized supports with individual budgets for living in the community. This is the biggest obstacle to having true, recovery-based care. The corollary to this is in the workforce itself. The workforce is trained to offer services according to models—and being accountable to agencies which are also organized around such models—instead of service workers being accountable and paid by the person with the psychiatric disability, via an individual budget and as negotiated with a fiscal intermediary. In a transformed mental health system, we see more about person-centered planning and person-centered budgets. We see a different sensibility regarding tax dollars. These dollars are not owned by social service vendors, but rather, through the aid of fiscal intermediaries, these dollars go into personal accounts for individual support and are then spent in a planned way by the person with psychiatric disabilities who has developed a personal recovery plan and an individualized budget. The person has a plan

to be accountable for the expenditure of those dollars, to maximize the value of those public dollars, by working with a public intermediary. This is the future we are looking at when we talk about the future of recovery care.

Jensen: I think from the consumer input I have heard that stigma is a significant obstacle. Further, consumers say that the stigma and ignorance is so bad that providers think they already are providing recovery-based care. In the United States, we have no central system of regulation that is in place that has been helpful in other countries such as in England, Australia or New Zealand, as they are moving toward cross-discipline services. We don't have some sort of overarching system to provide an umbrella for core competencies across disciplines that are the same, and then people can add their own discipline-based competencies. This is one of the things that the Annapolis Coalition is looking to address. What happens is that the language—kind of like the tower of Babel—needs development. Recovery in mental health is not the same as recovery in substance abuse. The core of the matter is that the words need to be useful across age groups, disciplines, cultures, service provision areas, and so we have a Tower of Babel situation where we may be talking about the same thing, but we can not come to the table to come up with the words. So what's happened is that whether you are a provider, or a family member, or even a consumer, people still think that they can decide whether recovery exists or not. Fortunately, there are accounts of recovery for hundreds of years. Recovery has nothing to do with whether they believe it or not. But, the criss-cross of language gets us bogged down in the idea that 'it can't possibly be true.'

Knight: I think the largest obstacle is the funding mechanisms, the fee for service mechanism—this promotes that if you are paid by the hour, you keep on doing more and more by the hour. This method of funding promotes dependencies and a psychology of adjustment. If *properly done*, capitation can promote recovery. The promotion of recovery through alternative funding mechanisms is not through fee-for-service, but through some form of capitation. You can talk about case rates, for example, or other capitation mechanisms like block grants with outcomes tied to the grant. Those kinds of mechanisms can promote recovery. While we continue with funding fee-for-service, there is more and more dependency created. I think that consumer services, when they are funded that way, will eventually promote dependency. This is why there has been so much controversy about Medicaid funding of consumer services. If you are paid by the hour, you will be driven to do more by the hour—even consumer providers. It's a simple survival mechanism. This tradition of funding mechanism helps create the psychology of adjustment culture. This culture has a set of roles and identities that professionals and other staff members occupy. They are essentially caretaking roles, not recovery roles, and so you'll find professionals forming their social identities around taking care of a group of people they think are totally hopeless. The second large obstacle is the culture being built around a psychology of adjustment versus a psychology of respect. The phrase "psychology of respect" is credited to Andrew Phelps, with the Accountability Caucus in California. These two obstacles can be addressed by: changing the funding mechanisms to some form of capitation, and as for the culture and identity issue, this is best changed through dialogues with consumer/survivors about what helps and hinders recovery, and through training.

5) From your interactions with the public mental health system workforce, is there more hope for recovery from mental illness today than there was ten years ago?

Deegan: I'd like to take a longer look back. As you know there are seven longitudinal studies in modern times that show recovery rates of one-half to two-thirds of people diagnosed with schizophrenia and other major mental disorders go on to significant or full recovery. Those studies span from the 1940s to the 1990s. But, there was a longitudinal study done at Worcester State Hospital in Massachusetts that was started in 1881. They looked at 211 patients who had been discharged as recovered between 1833-1840. The superintendent [in 1881] found that 51% of those discharged as recovered had remained well for as long as they lived. Between 1881-1893, the hospital sent letters to families of those who had been discharged from the hospital, and they looked at a total of 984 people discharged, and they found that 568 people remained well for the rest of their lives, or for as many as 40 years after discharge. They found that recovery rates between 1840-1893 were 58%. I know the danger of making a comparison between unmatched samples. However, the homogeneity of these rates with today's studies is striking. What can this homogeneity of data mean? Some might say it says something about the treatment, yet, the treatment has changed dramatically and recovery rates are about the same. When we are talking about recovery, we need to start thinking about recovery as a type of resilience, a drive to wellness, a self-righting capacity, a resourcefulness that people who were historically seen as vulnerable and afflicted can somehow bring to bear on their own recovery. This begins to change the human services landscape. Currently, we live in a time of unique opportunity. We have at the federal judiciary level the Olmstead Act in 1999, saying it is a form of illegal segregation to keep people in institutions longer than they need to be there. We have the legislature—the Americans with Disabilities Act—saying that people have the right to accessible voting, transportation, communication, mobility, and equal opportunity to work. Now we have the executive branch with the President's New Freedom Commission. So we have these three major things converging and it opens a unique window of opportunity. The grave danger of this time is - are we going to look at transformation as a matter of rearranging the chairs on the deck of the Titanic? Change is no guarantee of progress. If there is going to be one thing that each state does to bring about real mental health system transformation, let's get at least one demonstration project of self-directed care up and running in each of the states and territories.

Jensen: The short answer is absolutely and absolutely not. The first part of my answer is absolutely. There are individuals with life experience who are hired by everyone from the federal government to local agencies, and they are hired to do peer services, organizational change, education on recovery, and this is where change happens on the front lines. For most individuals doing this sort of work, such as a development specialist, or consumer specialist, this is isolated work. Even though I have my professional license and I have had my license for 25 years, I am no longer a nurse as a disclosed person. As a disclosed person, I am not necessarily a part of the staff from the point of view of everyone on the staff who is non-disclosed or a non-consumer. But, on the other hand, I am someone who does not have the court of peers, because I am a provider. It's like I'm

on an island in the river, with the river going by on both sides. There is hope in other ways, though. There is research, there are best practices, there's self-help, there's partnered collaborations that are already in existence that are supportable, fundable, and they are in demand. Further, there is the President's New Freedom Commission to bring a vision of recovery into being. Further, there are people with lived experience working in the system all over the country. Maybe there'll be a time when more people will become more recovery-oriented. Our current system is disease oriented, in that it is based in the disease model. Our system is still entrenched in that model. Perhaps there will come a time when self-disclosure will not be hazardous to your career, your professional health. There are more and more people self-educating about recovery who become people who can influence organizations in greater and greater ways. Many have started with GEDs and now they have PhDs. They are still living with symptoms, and are still recovering people. Further, there is more and more information that is carried on from person to person, to share concrete ways to make recovery possible. It's done primarily by word of mouth from people with lived experience. The answer to the question is absolutely. To answer the question in another way, the caution is that this is kind of like trying to water ski behind a six-masted, ruddered tall ship. They don't go fast, they don't turn fast, and they don't make waves. And if they make wakes, you have to get out of them. We are trying to get up on the water, but they don't go fast enough. Where it's bogged down is when people equate hope for recovery with that tall ship. Instead, you've got to equate it with the water skier who can swim faster than the ship. Maybe the water skier can succeed by finding an island, or they could find a way to get faster, maybe a motorboat. We need to change our perspective on this effort.

Knight: Because of the consumer/survivor movement, there is more hope now. We have pushed the notion of recovery, and we have pushed the notion of consumer-run and consumer-driven services in the field. I know of examples, some tragic examples, in some states and counties where there has been direct competition between consumer programs and day treatment programs run by the county. The consumer-run program was doing so much better than the day treatment programs, that the county took away the funding for the consumer-run program. This left an impact on people's minds. People indeed did better and preferred the service of a clubhouse over a day treatment program. I think the work that Larry Fricks has done in Georgia is great, and the work of Mary Ellen Copeland, and Joe Rogers from Southeastern Pennsylvania. Mary Ann Long of Meta Services in Phoenix. The work of Andrew Phelps, John Delman and Moira Armstrong in Massachusetts, the work of Howie Vogel with Double Trouble, the work of Bonnie Pate of South Carolina—all these various people—I am leaving out a lot of people. All of these modalities have pushed the system, nationwide. Most of these people have been noticed nationally in places where consumers do and teach recovery. Those kinds of outposts of recovery have been extremely important. All of these people have influenced the local and national scene.

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Web Sites

The following Web sites provide more information on issues related to implementing recovery-based care into today's public mental health system. They are listed in alphabetical order.

Boston University Center for Psychiatric Rehabilitation at Sargent College of Health and Rehabilitation Sciences

The mission of the Center is to “increase knowledge in the field of psychiatric rehabilitation and to apply this body of knowledge to train treatment personnel, to develop effective rehabilitation programs, and to assist in organizing both personnel and programs into efficient and coordinated service delivery systems.” The site includes information on recovery services, professional training, and a fantastic repository of online resources at www.bu.edu/cpr/recovery.

www.bu.edu/cpr/

Campaign for Mental Health Reform

The Web presence of a campaign “organized as the mental health community’s united voice on federal policy. Its goal is to make access, recovery, coherence, and quality in mental health services the hallmarks of our nation’s mental health system.”

www.mhreform.org/

Consumer/Survivor Mental Health Information from SAMHSA/CMHS

Site visitors can find a collection of guidance from the federal government’s Center for Mental Health Services on the topic of Recovery. The site includes information on federal programs on employment, housing, transportation, patient assistance plans, and self-help.

www.mentalhealth.samhsa.gov/consumersurvivor/recovery.asp

Consumer Organization and Networking Technical Assistance Center (CONTAC)

A self-help advocacy organization, CONTAC is a national technical assistance center that “serves as a resource center for consumers/survivors/ex-patients and consumer-run organizations across the United States, promoting self-help, recovery and empowerment.” The site offers access to training opportunities, program overviews, and great links to other peer support organizations.

<http://www.contac.org/>

Mary Ellen Copeland’s Mental Health Recovery Self-Help Strategies

A nationally known recovery educator and author of the Wellness Recovery Action Plan (WRAP), Copeland has produced a comprehensive Web site on her mental health recovery self-help strategies. Site visitors can read her Mental Health Recovery quarterly newsletter, register for training seminars, or order from her archive of publications, organizations, and Web sites that focus on Recovery. www.mentalhealthrecovery.com See also the <http://www.copelandcenter.com/> site.

NAMI

A leading voice in our nation's consumer advocacy community, NAMI (National Alliance for the Mentally Ill) has produced a site full of information on Recovery issues. The site's vault of info includes access to public awareness projects, models for self-help groups, contact with the National Consumer Council ("the only nationally convened representative body of persons living with mental illness"), and courses on illness management and wellness taught by people with mental illness, for people with mental illness.

www.nami.org

National Empowerment Center Inc.

In the site's own words: "The mission of the National Empowerment Center Inc. is to carry a message of recovery, empowerment, hope and healing to people who have been diagnosed with mental illness. We carry that message with authority because we are a consumer/survivor/expatient-run organization and each of us is living a personal journey of recovery and empowerment."

<http://www.power2u.org/>

National Mental Health Association

This renowned organization's Web site offers consumers help in creating a *Dialogue for Recovery*. The innovative NMHA program is "aimed at enhancing communication between doctors and patients about treatment goals, medication side-effects and other quality of life issues affecting the recovery of individuals diagnosed with serious mental illness." The site also offers helpful information on psychiatric advance directives, support services, and treatment options for recovery.

www.nmha.org

New Freedom Initiative: State Coalitions to Promote Community-Based Care

The federally funded program offers support and services to states to promote community-based care for adults with serious mental illness and children with severe emotional disturbances. Site visitors can order audio, MS PowerPoint, and text transcripts of "Retraining the Workforce to Support Recovery."

www.olmsteadcommunity.org

The President's New Freedom Commission on Mental Health

President George W. Bush created the commission in April 2002 as part of an effort to eliminate inequality for Americans with disabilities. Among other guiding principles, the commission was tasked to "promote successful community integration for adults with a serious mental illness and children with a serious emotional disturbance." The site includes access to a variety of reports and information including a report on consumer issues that calls for a "Recovery-Oriented Mental Health System."

www.mentalhealthcommission.gov

US Psychiatric Rehabilitation Association

The USPRA, formerly the International Association of Psychosocial Rehabilitation Services, helps “advance the role, scope, and quality of services designed to facilitate the community readjustment of people with psychiatric disabilities.” The group’s site offers information on the Psychiatric Rehabilitation Certification Program, a “test based certification program and enforcement of a practitioner code of ethics.” USPRA officials believe the credential will validate practitioners’ “knowledge, skill and ability to provide psychiatric services.”

<http://www.uspra.org/>