

## **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 (<http://www.dmhas.state.ct.us/>). 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](http://www.peoplewho.net)). Sister Ann Catherine Veierstahler has developed a Web site that contains personal stories of consumer recovery ([www.hopetohealing.com](http://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!

#### References

Campbell, J. (1998). Consumerism, outcomes, and satisfaction: A review of the literature. In Chapter 2 of R. W. Manderscheid, & M. J. Henderson (Eds.), *Mental health, United States, 1998*. DHHS Pub. No. (SMA) 99-3285. Rockville, MD: U.S. Department of Health and Human Services.

Institute of Medicine (IOM) Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: A new health system for the 21<sup>st</sup> century*. Washington, DC: National Academy Press.

Manderscheid, R. W. (2004). *Information technology can drive transformation*. Unpublished manuscript.

Manderscheid, R. W., & Henderson, M. J. (2003). A progress report on decision support 2000+. *Behavioral Health Management, 23*(2).

Manderscheid, R. W., & Henderson, M. J. (Eds.). (2004a). *Mental health, United States, 2002*. DHHS Pub. No. (SMA) 3938. Rockville, MD: U.S. Department of Health and Human Services.

Manderscheid, R. W., & Henderson, M. J. (2004b). From many into one: An integrated information agenda for mental health. *Behavioral Healthcare Tomorrow, 13*(1), 38-41.

Manderscheid, R. W., & Hutchings, G. P. (2004). Building comprehensive community care systems. *Journal of Mental Health, 13*(1), 37-41.

The President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: U.S. Department of Health and Human Services.