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Sciences

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## MEETING NOTICE

### LCSW Education Committee

**June 23, 2008**

CSU Long Beach  
"The Pointe" at the Pyramid  
1250 Bellflower Blvd.  
Long Beach, CA 90840  
(562) 985-8442 (CSULB Visitor Information)  
**9:30 a.m. – 3:00 p.m.**

- I. Introductions
- II. Purpose of the Committee
- III. Presentation about Mental Health Recovery from Chad Costello, MSW, of Mental Health America
- IV. Presentation about the Adoption of Mental Health Competencies and the Mental Health Stipend Program from Dr. Beverly Buckles of the California Social Work Education Center (CalSWEC)
- V. Future Meeting Dates
- VI. Suggestions for Future Agenda Items
- VII. Public Comment for Items Not on the Agenda

*Public Comment on items of discussion will be taken during each item. Time limitations will be determined by the Chairperson. Items will be considered in the order listed. Times are approximate and subject to change. Action may be taken on any item listed on the Agenda.*



Arnold Schwarzenegger  
Governor

State of California

State and Consumer  
Services Agency

Department of  
Consumer Affairs

THIS AGENDA AS WELL AS BOARD MEETING MINUTES CAN BE FOUND ON THE BOARD OF BEHAVIORAL SCIENCES WEBSITE AT [www.bbs.ca.gov](http://www.bbs.ca.gov)

NOTICE: The meeting facilities are accessible to persons with disabilities. Please make requests for accommodations to the attention of Christina Kitamura at the Board of Behavioral Sciences, 1625 N. Market Boulevard, Suite S-200, Sacramento, CA 95834, or by phone at 916-574-7835, no later than one week prior to the meeting. If you have any questions please contact the Board at (916) 574-7830.

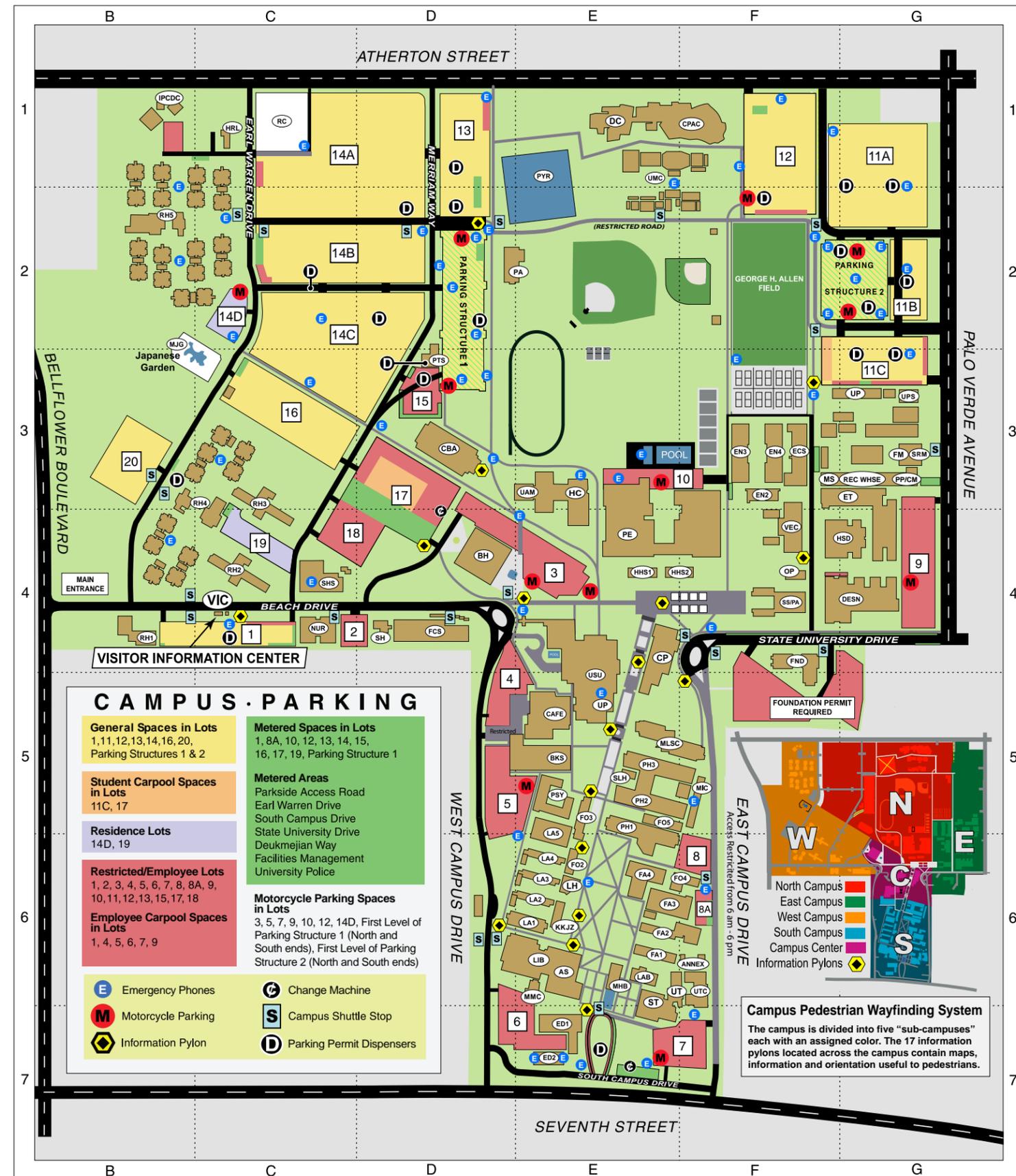
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# CALIFORNIA STATE UNIVERSITY, LONG BEACH

## 1250 BELLFLOWER BOULEVARD, LONG BEACH, CA 90840

Art Annex (ANNEX).....	F6	Library (LIB).....	E6
Art Museum (UAM).....	E3	McIntosh Humanities Bldg (MHB).....	E6
Academic Services (AS).....	E6	Mail Services (MS).....	F3
Bookstore (BKS).....	E5	Microbiology (MIC).....	F5
Brotman Hall (BH).....	D4	Japanese Gardens (MJG).....	B3
Cafeteria (CAFE).....	E5	Molecular & Life Sciences Center (MLSC).....	E3
Campus Events (PA).....	D2	Multi-Media Center (MMC).....	D6
Carpenter Performing Arts Center (CPAC).....	F1	Music Center (UMC).....	E1
Central Plant (CP).....	E5	Nursing (NUR).....	C4
College of Business Administration (CBA).....	D3	Outpost (OP).....	F4
Dance Center (DC).....	E1	Parking, Transportation & Event Services (PTS).....	D3
Design (DESN).....	F4	Peterson Hall 1 (PH1).....	E5
Earl Burns Miller Japanese Garden (MJG).....	B3	Peterson Hall 2 (PH2).....	E5
Education 1 (ED1).....	E7	Peterson Hall 3 (PH3).....	E5
Education 2 (ED2).....	E7	Physical Education/Gym (PE).....	E4
Engineering 2 (EN2).....	F3	Physical Planning/Construction Mgmt. (PP/CM).....	G3
Engineering 3 (EN3).....	F3	Pool.....	E3
Engineering 4 (EN4).....	F3	Psychology (PSY).....	E5
Engr & Computer Sciences (ECS).....	F3	Quick Copy (BH).....	D4
Engineering Technology (ET).....	G3	Pyramid (PYR).....	E1
Facilities Management (FM).....	G3	Pyramid Annex (PA).....	D2
Faculty Office 2 (FO2).....	E6	Recycling Center (RC).....	C1
Faculty Office 3 (FO3).....	E5	Residence Housing	
Faculty Office 4 (FO4).....	F6	International House (RH1).....	B4
Faculty Office 5 (FO5).....	E5	Los Cerritos (RH2).....	C3
Family & Consumer Sciences (FCS).....	D4	Los Alamitos (RH3).....	C4
Fine Arts 1 (FA1).....	E6	Residence Commons (RH4).....	B3
Fine Arts 2 (FA2).....	E6	Parkside Commons (RH5).....	B2
Fine Arts 3 (FA3).....	E6	Safety and Risk Management (SRM).....	G3
Fine Arts 4 (FA4).....	E6	Science Lecture Hall (SLH).....	E5
Art Annex (ANNEX).....	F6	Shipping/Receiving (REC WHSE).....	F3
Foundation (FND).....	F4	Social Sciences/Public Admin (SS/PA).....	F4
KKJZ/FM (KKJZ).....	E6	Soroptomist House (SH).....	D4
Health & Human Services 1 Classrooms (HHS1).....	E4	Steve and Nini Horn Center (HC).....	E3
Health & Human Services 2 Offices (HHS2).....	E4	Student Health Services (SHS).....	C4
Horn Center (HC).....	E3	Studio Theatre (ST).....	E7
Housing & Residential Life (HRL).....	C1	Univ. College and Extension Services (FND).....	F4
Isabel Patterson Child Development Center (IPCDC).....	B1	University Art Museum (UAM).....	E3
Language Arts Building (LAB).....	E6	University Music Center (UMC).....	E1
Lecture Halls 150/151 (LH).....	E6	University Police (UP).....	G3, E5
Liberal Arts 1 (LA1).....	D6	University Print Shop (UPS).....	G3
Liberal Arts 2 (LA2).....	E6	University Student Union (USU).....	E4
Liberal Arts 3 (LA3).....	E6	University Telecommunications (UTC).....	F6
Liberal Arts 4 (LA4).....	E6	University Theater (UT).....	E6
Liberal Arts 5 (LA5).....	E5	Visitor Information Center (VIC).....	C4
		Vivian Engineering Center (VEC).....	F4

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## **CSULB PARKING AND MEETING ROOM LOCATION**

Visitor parking permits will be available for pick up on the day of the meeting at the Visitor Information Center (this is a drive thru window). Parking will be made available in the general parking lots located near the Pyramid. The VIC booth attendant can direct participants to the Pyramid.

The Pyramid is located on the north side of campus near Atherton Street and the entrance to the Pointe is on the West side of the Pyramid on the ground floor.

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## Background

Recovery is cited, within *Transforming Mental Health Care in America, Federal Action Agenda: First Steps*, as the “single most important goal” for the mental health service delivery system.

To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Inter-agency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004.

Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels. The following consensus statement was derived from expert panelist deliberations on the findings.

*Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.*

### The 10 Fundamental Components of Recovery

- **Self-Direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual’s unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
- **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so

doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

- **Holistic:** Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- **Non-Linear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

- **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect:** Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

- **Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

### Components of Recovery



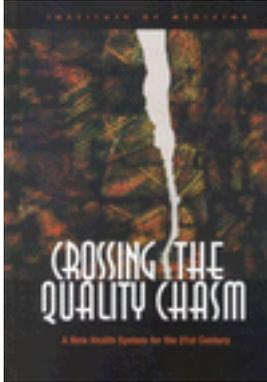
**Resources**  
[www.samhsa.gov](http://www.samhsa.gov)  
 National Mental Health Information Center  
 1-800-789-2647, 1-866-889-2647 (TDD)

# NATIONAL CONSENSUS STATEMENT ON MENTAL HEALTH RECOVERY



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 Substance Abuse and Mental Health Services Administration  
 Center for Mental Health Services  
[www.samhsa.gov](http://www.samhsa.gov)

## Free Executive Summary



### Crossing the Quality Chasm: A New Health System for the 21st Century

Committee on Quality of Health Care in America,  
Institute of Medicine

ISBN: 978-0-309-07280-9, 364 pages, 6 x 9, hardback (2001)

This free executive summary is provided by the National Academies as part of our mission to educate the world on issues of science, engineering, and health. If you are interested in reading the full book, please visit us online at <http://www.nap.edu/catalog/10027.html>. You may browse and search the full, authoritative version for free; you may also purchase a print or electronic version of the book. If you have questions or just want more information about the books published by the National Academies Press, please contact our customer service department toll-free at 888-624-8373.

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## Executive Summary

The American health care delivery system is in need of fundamental change. Many patients, doctors, nurses, and health care leaders are concerned that the care delivered is not, essentially, the care we should receive (Donelan et al., 1999; Reed and St. Peter, 1997; Shindul-Rothschild et al., 1996; Taylor, 2001). The frustration levels of both patients and clinicians have probably never been higher. Yet the problems remain. Health care today harms too frequently and routinely fails to deliver its potential benefits.

Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge. Yet there is strong evidence that this frequently is not the case.<sup>1</sup> Crucial reports from disciplined review bodies document the scale and gravity of the problems (Chassin et al., 1998; Institute of Medicine, 1999; Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1998). Quality problems are everywhere, affecting many patients. Between the health care we have and the care we could have lies not just a gap, but a chasm.

The Committee on the Quality of Health Care in America was formed in June 1998 and charged with developing a strategy that would result in a substantial improvement in the quality of health care over the next 10 years. In carrying out this charge, the committee commissioned a detailed review of the literature on the quality of care; convened a communications workshop to identify strategies for raising the awareness of the general public and key stakeholders of quality concerns; identified environmental forces that encourage or impede ef-

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<sup>1</sup>See Appendix A of this report for a review of the literature on the quality of care.

forts to improve quality; developed strategies for fostering greater accountability for quality; and identified important areas of research that should be pursued to facilitate improvements in quality. The committee has focused on the personal health care delivery system, specifically, the provision of preventive, acute, chronic, and end-of-life health care for individuals. Although the committee recognizes the critical role of the public health system in protecting and improving the health of our communities, this issue lies beyond the purview of the present study.

The committee has already spoken to one urgent quality problem—patient safety. In our first report, *To Err Is Human: Building a Safer Health System*, we concluded that tens of thousands of Americans die each year from errors in their care, and hundreds of thousands suffer or barely escape from nonfatal injuries that a truly high-quality care system would largely prevent (Institute of Medicine, 2000b).

As disturbing as the committee's report on safety is, it reflects only a small part of the unfolding story of quality in American health care. Other defects are even more widespread and, taken together, detract still further from the health, functioning, dignity, comfort, satisfaction, and resources of Americans. This report addresses these additional quality problems. As the patient safety report was a call for action to make care safer, this report is a call for action to improve the American health care delivery system as a whole, in all its quality dimensions, for all Americans.

### WHY ACTION IS NEEDED NOW

At no time in the history of medicine has the growth in knowledge and technologies been so profound. Since the first contemporary randomized controlled trial was conducted more than 50 years ago, the number of trials conducted has grown to nearly 10,000 annually (Chassin, 1998). Between 1993 and 1999, the budget of the National Institutes of Health increased from \$10.9 to \$15.6 billion, while investments by pharmaceutical firms in research and development increased from \$12 to \$24 billion (National Institutes of Health, 2000; Pharmaceutical Research and Manufacturers of America, 2000). Genomics and other new technologies on the horizon offer the promise of further increasing longevity, improving health and functioning, and alleviating pain and suffering. Advances in rehabilitation, cell restoration, and prosthetic devices hold potential for improving the health and functioning of many with disabilities. Americans are justifiably proud of the great strides that have been made in the health and medical sciences.

As medical science and technology have advanced at a rapid pace, however, the health care delivery system has floundered in its ability to provide consistently high-quality care to all Americans. Research on the quality of care reveals

a health care system that frequently falls short in its ability to translate knowledge into practice, and to apply new technology safely and appropriately. During the last decade alone, more than 70 publications in leading peer-reviewed journals have documented serious quality shortcomings (see Appendix A). The performance of the health care system varies considerably. It may be exemplary, but often is not, and millions of Americans fail to receive effective care. If the health care system cannot consistently deliver today's science and technology, we may conclude that it is even less prepared to respond to the extraordinary scientific advances that will surely emerge during the first half of the 21st century. And finally, more than 40 million Americans remain without health insurance, deprived of critically important access to basic care (U.S. Census Bureau, 2000).

The health care system as currently structured does not, as a whole, make the best use of its resources. There is little doubt that the aging population and increased patient demand for new services, technologies, and drugs are contributing to the steady increase in health care expenditures, but so, too, is waste. Many types of medical errors result in the subsequent need for additional health care services to treat patients who have been harmed (Institute of Medicine, 2000b). A highly fragmented delivery system that largely lacks even rudimentary clinical information capabilities results in poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays. And there is substantial evidence documenting overuse of many services—services for which the potential risk of harm outweighs the potential benefits (Chassin et al., 1998; Schuster et al., 1998).

What is perhaps most disturbing is the absence of real progress toward restructuring health care systems to address both quality and cost concerns, or toward applying advances in information technology to improve administrative and clinical processes. Despite the efforts of many talented leaders and dedicated professionals, the last quarter of the 20th century might best be described as the “era of Brownian motion in health care.” Mergers, acquisitions, and affiliations have been commonplace within the health plan, hospital, and physician practice sectors (Colby, 1997). Yet all this organizational turmoil has resulted in little change in the way health care is delivered. Some of the new arrangements have failed following disappointing results. Leaders of health care institutions are under extraordinary pressure, trying on the one hand to strategically reposition their organizations for the future, and on the other to respond to today's challenges, such as reductions in third-party payments (Guterman, 1998), shortfalls in nurse staffing (Egger, 2000), and growing numbers of uninsured patients seeking uncompensated care (Institute of Medicine, 2000a).

For several decades, the needs of the American public have been shifting from predominantly acute, episodic care to care for chronic conditions. Chronic conditions are now the leading cause of illness, disability, and death; they affect almost half of the U.S. population and account for the majority of health care

expenditures (Hoffman et al., 1996; The Robert Wood Johnson Foundation, 1996). As the need for community-based acute and long-term care services has grown, the portion of health care resources devoted to hospital care has declined, while that expended on pharmaceuticals has risen dramatically (Copeland, 1999). Yet there remains a dearth of clinical programs with the infrastructure required to provide the full complement of services needed by people with heart disease, diabetes, asthma, and other common chronic conditions (Wagner et al., 1996). The fact that more than 40 percent of people with chronic conditions have more than one such condition argues strongly for more sophisticated mechanisms to communicate and coordinate care (The Robert Wood Johnson Foundation, 1996). Yet physician groups, hospitals, and other health care organizations operate as silos, often providing care without the benefit of complete information about the patient's condition, medical history, services provided in other settings, or medications prescribed by other clinicians. For those without insurance, care is often unobtainable except in emergencies. It is not surprising, then, that studies of patient experience document that the health system for some is a "nightmare to navigate" (Picker Institute and American Hospital Association, 1996).

### QUALITY AS A SYSTEM PROPERTY

The committee is confident that Americans can have a health care system of the quality they need, want, and deserve. But we are also confident that this higher level of quality cannot be achieved by further stressing current systems of care. The current care systems cannot do the job. Trying harder will not work. Changing systems of care will.

The committee's report on patient safety offers a similar conclusion in its narrower realm. Safety flaws are unacceptably common, but the effective remedy is not to browbeat the health care workforce by asking them to try harder to give safe care. Members of the health care workforce are already trying hard to do their jobs well. In fact, the courage, hard work, and commitment of doctors, nurses, and others in health care are today the only real means we have of stemming the flood of errors that are latent in our health care systems.

Health care has safety and quality problems because it relies on outmoded systems of work. Poor designs set the workforce up to fail, regardless of how hard they try. If we want safer, higher-quality care, we will need to have redesigned systems of care, including the use of information technology to support clinical and administrative processes.

Throughout this report, the committee offers a strategy and action plan for building a stronger health system over the coming decade, one that is capable of delivering on the promise of state-of-the-art health care to all Americans. In some areas, achieving this ideal will require crossing a large chasm between today's system and the possibilities of tomorrow.

## AN AGENDA FOR CROSSING THE CHASM

The need for leadership in health care has never been greater. Transforming the health care system will not be an easy process. But the potential benefits are large as well. Narrowing the quality chasm will make it possible to bring the benefits of medical science and technology to all Americans in every community, and this in turn will mean less pain and suffering, less disability, greater longevity, and a more productive workforce. To this end, the committee proposes the following agenda for redesigning the 21st-century health care system:

- **That all health care constituencies, including policymakers, purchasers, regulators, health professionals, health care trustees and management, and consumers, commit to a national statement of purpose for the health care system as a whole and to a shared agenda of six aims for improvement that can raise the quality of care to unprecedented levels.**

- **That clinicians and patients, and the health care organizations that support care delivery, adopt a new set of principles to guide the redesign of care processes.**

- **That the Department of Health and Human Services identify a set of priority conditions upon which to focus initial efforts, provide resources to stimulate innovation, and initiate the change process.**

- **That health care organizations design and implement more effective organizational support processes to make change in the delivery of care possible.**

- **That purchasers, regulators, health professions, educational institutions, and the Department of Health and Human Services create an environment that fosters and rewards improvement by (1) creating an infrastructure to support evidence-based practice, (2) facilitating the use of information technology, (3) aligning payment incentives, and (4) preparing the workforce to better serve patients in a world of expanding knowledge and rapid change.**

The committee recognizes that implementing this agenda will be a complex process and that it will be important to periodically evaluate progress and reassess strategies for overcoming barriers.

### Establishing Aims for the 21st-Century Health Care System

The committee proposes six aims for improvement to address key dimensions in which today's health care system functions at far lower levels than it can and should. Health care should be:

- *Safe*—avoiding injuries to patients from the care that is intended to help them.

- *Effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- *Patient-centered*—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- *Timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care.
- *Efficient*—avoiding waste, including waste of equipment, supplies, ideas, and energy.
- *Equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

A health care system that achieved major gains in these six dimensions would be far better at meeting patient needs. Patients would experience care that was safer, more reliable, more responsive, more integrated, and more available. Patients could count on receiving the full array of preventive, acute, and chronic services from which they are likely to benefit. Such a system would also be better for clinicians and others who would experience the satisfaction of providing care that was more reliable, more responsive to patients, and more coordinated than is the case today.

The entire enterprise of care would ideally be united across these aims by a single, overarching purpose for the American health care system as a whole. For this crucial statement of purpose, the committee endorses and adopts the phrasing of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry (1998).

**Recommendation 1: All health care organizations, professional groups, and private and public purchasers should adopt as their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States.**

**Recommendation 2: All health care organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient, and equitable.**

Additionally, without ongoing tracking to assess progress in meeting the six aims, policy makers, leaders within the health professions and health organizations, purchasers, and consumers will be unable to determine progress or understand where improvement efforts have succeeded and where further work is most needed. The National Quality Report has the potential to play an important role

in continuing to raise the awareness of the American public about the quality-of-care challenges facing the health care system. Public awareness of shortcomings in quality is critical to securing public support for the steps that must be taken to address these concerns.

**Recommendation 3: Congress should continue to authorize and appropriate funds for, and the Department of Health and Human Services should move forward expeditiously with the establishment of, monitoring and tracking processes for use in evaluating the progress of the health system in pursuit of the above-cited aims of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. The Secretary of the Department of Health and Human Services should report annually to Congress and the President on the quality of care provided to the American people.**

The committee applauds Congress and the Administration for their current efforts to establish a National Quality Report for tracking the quality of care. Ongoing input from the many public- and private-sector associations, professional groups, and others involved in quality measurement and improvement will contribute to the success of these efforts. The establishment of specific goals for each of the six aims could further enhance the usefulness of this monitoring and tracking system as a stimulus for performance improvement. Continued funding for this activity should be ensured, as well as regular reports that communicate progress to all concerned. It should be noted that although this report focuses only on health care for individuals, the above overarching statement of purpose and six aims for improvement are sufficiently robust that they can be applied equally to decisions and evaluations at the population–health level.

### **Formulating New Rules to Redesign and Improve Care**

As discussed earlier, improved performance will depend on new system designs. The committee believes it would be neither useful nor possible for us to specify in detail the design of 21st-century health care delivery systems. Imagination and valuable pluralism abound at the local level in the nation’s health care enterprise. At the same time, we believe local efforts to implement innovation and achieve improvement can benefit from a set of simple rules to guide the redesign of the health care system.

In formulating these rules, the committee has been guided by the belief that care must be delivered by systems that are carefully and consciously designed to provide care that is safe, effective, patient-centered, timely, efficient, and equitable. Such systems must be designed to serve the needs of patients, and to ensure that they are fully informed, retain control and participate in care delivery whenever possible, and receive care that is respectful of their values and preferences. Such systems must facilitate the application of scientific knowledge to

practice, and provide clinicians with the tools and supports necessary to deliver evidence-based care consistently and safely.

**Recommendation 4: Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes in accordance with the following rules:**

*1. Care based on continuous healing relationships.* Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.

*2. Customization based on patient needs and values.* The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.

*3. The patient as the source of control.* Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.

*4. Shared knowledge and the free flow of information.* Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

*5. Evidence-based decision making.* Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.

*6. Safety as a system property.* Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

*7. The need for transparency.* The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

*8. Anticipation of needs.* The health system should anticipate patient needs, rather than simply reacting to events.

**9. Continuous decrease in waste. The health system should not waste resources or patient time.**

**10. Cooperation among clinicians. Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.**

The above rules will lead the redesign effort in the right direction, guiding the innovation required to achieve the aims for improvement outlined earlier. Widespread application of these ten rules, each grounded in both logic and varying degrees of evidence, will represent a new paradigm for health care delivery. As the redesign effort moves forward, it will be important to assess not only progress toward meeting the aims, but also the specific effects attributable to the new rules and to adapt the rules as appropriate.

Design ideas are not enough, however. To initiate the process of change, both an action agenda and resources are needed.

### **Taking the First Steps**

The committee recognizes the enormity of the change that will be required to achieve a substantial improvement in the nation's health care system. Although steps can be taken immediately to apply the ten rules set forth above to the redesign of health care, widespread application will require commitment to the provision of evidence-based care that is responsive to individual patients' needs and preferences. Well-designed and well-run systems of care will be required as well. These changes will occur most rapidly in an environment in which public policy and market forces are aligned and in which the change process is supported by an appropriate information technology infrastructure.

To initiate the process of change, the committee believes the health care system must focus greater attention on the development of care processes for the common conditions that afflict many people. A limited number of such conditions, about 15 to 25, account for the majority of health care services (Centers for Disease Control and Prevention, 1999; Medical Expenditure Panel Survey, 2000; Ray et al., 2000). Nearly all of these conditions are chronic. By focusing attention on a limited number of common conditions, the committee believes it will be possible to make sizable improvements in the quality of care received by many individuals within the coming decade.

Health care for chronic conditions is very different from care for acute episodic illnesses. Care for the chronically ill needs to be a collaborative, multidisciplinary process. Effective methods of communication, both among caregivers and between caregivers and patients, are critical to providing high-quality care. Personal health information must accompany patients as they transition from home to clinical office setting to hospital to nursing home and back.

Carefully designed, evidence-based care processes, supported by automated clinical information and decision support systems, offer the greatest promise of achieving the best outcomes from care for chronic conditions. Some efforts are now under way to synthesize the clinical evidence pertaining to common chronic conditions and to make this information available to consumers and clinicians on the Web and by other means (Lindberg and Humphreys, 1999). In addition, evidence-based practice guidelines have been developed for many chronic conditions (Eisenberg, 2000). Yet studies of the quality of care document tremendous variability in practice for many such conditions. Given these variations and the prevalence of chronic conditions, these conditions represent an excellent starting point for efforts to better define optimum care or best practices, and to design care processes to meet patient needs. Moreover, such efforts to improve quality must be supported by payment methods that remove barriers to integrated care and provide strong incentives and rewards for improvement.

To facilitate this process, the Agency for Healthcare Research and Quality should identify a limited number of priority conditions that affect many people and account for a sizable portion of the national health burden and associated expenditures. In identifying these priority conditions, the agency should consider using the list of conditions identified through the Medical Expenditure Panel Survey (2000). According to the most recent survey data, the top 15 priority conditions are cancer, diabetes, emphysema, high cholesterol, HIV/AIDS, hypertension, ischemic heart disease, stroke, arthritis, asthma, gall bladder disease, stomach ulcers, back problems, Alzheimer's disease and other dementias, and depression and anxiety disorders. Health care organizations, clinicians, purchasers, and other stakeholders should then work together to (1) organize evidence-based care processes consistent with best practices, (2) organize major prevention programs to target key health risk behaviors associated with the onset or progression of these conditions, (3) develop the information infrastructure needed to support the provision of care and the ongoing measurement of care processes and patient outcomes, and (4) align the incentives inherent in payment and accountability processes with the goal of quality improvement.

**Recommendation 5: The Agency for Healthcare Research and Quality should identify not fewer than 15 priority conditions, taking into account frequency of occurrence, health burden, and resource use. In collaboration with the National Quality Forum, the agency should convene stakeholders, including purchasers, consumers, health care organizations, professional groups, and others, to develop strategies, goals, and action plans for achieving substantial improvements in quality in the next 5 years for each of the priority conditions.**

Redirecting the health care industry toward the implementation of well-designed care processes for priority conditions will require significant resources.

Capital will be required to invest in enhancing organizational capacity, building an information infrastructure, and training multidisciplinary care teams, among other things. The committee believes it is appropriate for the public sector to take the lead in establishing an innovation fund to seed promising projects, but not to shoulder the full burden of the transition. Private-sector organizations, including foundations, purchasers, health care organizations, and others, should also make investments. High priority should be given to projects that are likely to result in making available in the public domain new programs, tools, and technologies that are broadly applicable throughout the health care sector.

**Recommendation 6: Congress should establish a Health Care Quality Innovation Fund to support projects targeted at (1) achieving the six aims of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity; and/or (2) producing substantial improvements in quality for the priority conditions. The fund's resources should be invested in projects that will produce a public-domain portfolio of programs, tools, and technologies of widespread applicability.**

Americans now invest annually \$1.1 trillion, or 13.5 percent, of the nation's gross domestic product (GDP) in the health care sector (Health Care Financing Administration, 1999). This figure is expected to grow to more than \$2 trillion, or 16 percent of GDP, by 2007 (Smith et al., 1998). The committee believes a sizable commitment, on the order of \$1 billion over 3 to 5 years, is needed to strongly communicate the need for rapid and significant change in the health care system and to help initiate the transition. Just as a vigorous public commitment has led to the mapping of human DNA, a similar commitment is needed to help the nation's health care system achieve the aims for improvement outlined above.

### **Building Organizational Supports for Change**

Supporting front-line teams that deliver care are many types of health care organizations. Today, these are hospitals, physician practices, clinics, integrated delivery systems, and health plans, but new forms will unquestionably emerge. Whatever those forms, care that is responsive to patient needs and makes consistent use of the best evidence requires far more conscious and careful organization than we find today.

Organizations will need to negotiate successfully six major challenges. The first is to redesign care processes to serve more effectively the needs of the chronically ill for coordinated, seamless care across settings and clinicians and over time. The use of tools to organize and deliver care has lagged far behind biomedical and clinical knowledge. A number of well-understood design principles, drawn from other industries as well as some of today's health care organizations, could help greatly in improving the care that is provided to patients.

A second challenge is making effective use of information technologies to automate clinical information and make it readily accessible to patients and all members of the care team. An improved information infrastructure is needed to establish effective and timely communication among clinicians and between patients and clinicians.

A third challenge is to manage the growing knowledge base and ensure that all those in the health care workforce have the skills they need. Making use of new knowledge requires that health professionals develop new skills or assume new roles. It requires that they use new tools to access and apply the expanding knowledge base. It also requires that training and ongoing licensure and certification reflect the need for lifelong learning and evaluation of competencies.

A fourth challenge for organizations is coordination of care across patient conditions, services, and settings over time. Excellent information technologies and well-thought-out and -implemented modes of ongoing communication can reduce the need to craft laborious, case-by-case strategies for coordinating patient care.

A fifth challenge is to continually advance the effectiveness of teams. Team practice is common, but the training of health professionals is typically isolated by discipline. Making the necessary changes in roles to improve the work of teams is often slowed or stymied by institutional, labor, and financial structures, and by law and custom.

Finally, all organizations—whether or not health care related—can improve their performance only by incorporating care process and outcome measures into their daily work. Use of such measures makes it possible to understand the degree to which performance is consistent with best practices, and the extent to which patients are being helped.

**Recommendation 7: The Agency for Healthcare Research and Quality and private foundations should convene a series of workshops involving representatives from health care and other industries and the research community to identify, adapt, and implement state-of-the-art approaches to addressing the following challenges:**

- **Redesign of care processes based on best practices**
- **Use of information technologies to improve access to clinical information and support clinical decision making**
  - **Knowledge and skills management**
  - **Development of effective teams**
  - **Coordination of care across patient conditions, services, and settings over time**
  - **Incorporation of performance and outcome measurements for improvement and accountability**

### Establishing a New Environment for Care

To enable the profound changes in health care recommended in this report, the *environment* of care must also change. The committee believes the current environment often inhibits the changes needed to achieve quality improvement. Two types of environmental change are needed:

- *Focus and align the environment toward the six aims for improvement.* To effect this set of changes, purchasers and health plans, for example, should eliminate or modify payment practices that fragment the care system, and should establish incentives designed to encourage and reward innovations aimed at improving quality. Purchasers and regulators should also create precise streams of accountability and measurement reflecting achievements in the six aims. Moreover, efforts should be made to help health care consumers understand the aims, why they are important, and how to interpret the levels of performance of various health care systems.

- *Provide, where possible, assets and encouragement for positive change.* For example, national funding agencies could promote research on new designs for the care of priority conditions, state and national activities could be undertaken to facilitate the exchange of best practices and shared learning among health care delivery systems, and a national system for monitoring progress toward the six aims for improvement could help improvement efforts remain on track.

Such environmental changes need to occur in four major areas: the infrastructure that supports the dissemination and application of new clinical knowledge and technologies, the information technology infrastructure, payment policies, and preparation of the health care workforce.

Changes will also be needed in the quality oversight and accountability processes of public and private purchasers. This issue is not addressed here. The IOM will be issuing a separate report on federal quality measurement and improvement programs in Fall 2002. In addition, the National Quality Forum has an extensive effort under way to develop a national framework for quality measurement and accountability and will be issuing a report in Summer 2001.

### *Applying Evidence to Health Care Delivery*

In the current health care system, scientific knowledge about best care is not applied systematically or expeditiously to clinical practice. An average of about 17 years is required for new knowledge generated by randomized controlled trials to be incorporated into practice, and even then application is highly uneven (Balas and Boren, 2000). The extreme variability in practice in clinical areas in

which there is strong scientific evidence and a high degree of expert consensus about best practices indicates that current dissemination efforts fail to reach many clinicians and patients, and that there are insufficient tools and incentives to promote rapid adoption of best practices. The time has come to invest in the creation of a more effective infrastructure for the application of knowledge to health care delivery.

**Recommendation 8: The Secretary of the Department of Health and Human Services should be given the responsibility and necessary resources to establish and maintain a comprehensive program aimed at making scientific evidence more useful and accessible to clinicians and patients. In developing this program, the Secretary should work with federal agencies and in collaboration with professional and health care associations, the academic and research communities, and the National Quality Forum and other organizations involved in quality measurement and accountability.**

It is critical that leadership from the private sector, both professional and other health care leaders and consumer representatives, be involved in all aspects of this effort to ensure its applicability and acceptability to clinicians and patients. The infrastructure developed through this public- and private-sector partnership should focus initially on priority conditions and include:

- Ongoing analysis and synthesis of the medical evidence
- Delineation of specific practice guidelines
- Identification of best practices in the design of care processes
- Enhanced dissemination efforts to communicate evidence and guidelines to the general public and professional communities
  - Development of decision support tools to assist clinicians and patients in applying the evidence
  - Establishment of goals for improvement in care processes and outcomes
  - Development of quality measures for priority conditions

More systematic approaches are needed to analyze and synthesize medical evidence for both clinicians and patients. Far more sophisticated clinical decision support systems will be required to assist clinicians and patients in selecting the best treatment options and delivering safe and effective care. Many promising private- and public-sector activities now under way can serve as excellent models and building blocks for a more expanded effort. In particular, the Cochrane Collaboration and the Agency for Healthcare Research and Quality's Evidence-Based Practice Centers represent important efforts to synthesize medical evidence. The growth of the Internet has also opened up many new opportunities to make evidence more accessible to clinicians and consumers. The efforts of the National Library of Medicine to facilitate access to the medical literature

by both consumers and health care professionals and to design Web sites that organize large amounts of information on particular health needs are particularly promising.

The development of a more effective infrastructure to synthesize and organize evidence around priority conditions would also offer new opportunities to enhance quality measurement and reporting. A stronger and more organized evidence base should facilitate the adoption of best practices, as well as the development of valid and reliable quality measures for priority conditions that could be used for both internal quality improvement and external accountability.

### *Using Information Technology*

Health care delivery has been relatively untouched by the revolution in information technology that has been transforming nearly every other aspect of society. The majority of patient and clinician encounters take place for purposes of exchanging clinical information: patients share information with clinicians about their general health, symptoms, and concerns, and clinicians use their knowledge and skills to respond with pertinent medical information, and in many cases reassurance. Yet it is estimated that only a small fraction of physicians offer e-mail interaction, a simple and convenient tool for efficient communication, to their patients (Hoffman, 1997).

The meticulous collection of personal health information throughout a patient's life can be one of the most important inputs to the provision of proper care. Yet for most individuals, that health information is dispersed in a collection of paper records that are poorly organized and often illegible, and frequently cannot be retrieved in a timely fashion, making it nearly impossible to manage many forms of chronic illness that require frequent monitoring and ongoing patient support.

Although growth in clinical knowledge and technology has been profound, many health care settings lack basic computer systems to provide clinical information or support clinical decision making. The development and application of more sophisticated information systems is essential to enhance quality and improve efficiency.

The Internet has enormous potential to transform health care through information technology applications in such areas as consumer health, clinical care, administrative and financial transactions, public health, professional education, and biomedical and health services research (National Research Council, 2000). Many of these applications are currently within reach, including remote medical consultation with patients in their homes or offices; consumer and clinician access to the medical literature; creation of "communities" of patients and clinicians with shared interests; consumer access to information on health plans, participating providers, eligibility for procedures, and covered drugs in a formulary; and videoconferencing among public health officials during emergency

situations. Other applications are more experimental, such as simulation of surgical procedures; consultation among providers involving manipulation of digital images; and control of experimental equipment, such as electron microscopes.

The Internet also supports rising interest among consumers in information and convenience in all areas of commerce, including health care. The number of Americans who use the Internet to retrieve health-related information is estimated to be about 70 million (Cain et al., 2000). Consumers access health-related Web sites to research an illness or disease; seek information on nutrition and fitness; research drugs and their interactions; and search for doctors, hospitals, and online medical support groups.

The committee believes information technology must play a central role in the redesign of the health care system if a substantial improvement in quality is to be achieved over the coming decade. Automation of clinical, financial, and administrative transactions is essential to improving quality, preventing errors, enhancing consumer confidence in the health system, and improving efficiency.

Central to many information technology applications is the automation of patient-specific clinical information. A fully electronic medical record, including all types of patient information, is not needed to achieve many, if not most, of the benefits of automated clinical data. Sizable benefits can be derived in the near future from automating certain types of data, such as medication orders. Efforts to automate clinical information date back several decades, but progress has been slow (Institute of Medicine, 1991), in part because of the barriers and risks involved. An important constraint is that consumers and policy makers share concerns about the privacy and confidentiality of these data (Cain et al., 2000; Goldman, 1998). The United States also lacks national standards for the capture, storage, communication, processing, and presentation of health information (Work Group on Computerization of Patient Records, 2000).

The challenges of applying information technology to health care should not be underestimated. Health care is undoubtedly one of the most, if not the most, complex sectors of the economy. The number of different types of transactions (i.e., patient needs, interactions, and services) is very large. Sizable capital investments and multiyear commitments to building systems will be required. Widespread adoption of many information technology applications will require behavioral adaptations on the part of large numbers of patients, clinicians, and organizations. Yet, the Internet is rapidly transforming many aspects of society, and many health-related processes stand to be reshaped as well.

In the absence of a national commitment and financial support to build a national health information infrastructure, the committee believes that progress on quality improvement will be painfully slow. The automation of clinical, financial, and administrative information and the electronic sharing of such information among clinicians, patients, and appropriate others within a secure environment are critical if the 21st-century health care system envisioned by the committee is to be realized.

**Recommendation 9: Congress, the executive branch, leaders of health care organizations, public and private purchasers, and health informatics associations and vendors should make a renewed national commitment to building an information infrastructure to support health care delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research, and clinical education. This commitment should lead to the elimination of most handwritten clinical data by the end of the decade.**

*Aligning Payment Policies with Quality Improvement*

Current payment methods do not adequately encourage or support the provision of quality health care. Although payment is not the only factor that influences provider and patient behavior, it is an important one.

All payment methods affect behavior and quality. For example, fee-for-service payment methods for physicians and hospitals raise concerns about potential overuse of services—the provision of services that may not be necessary or may expose the patient to greater potential harm than benefit. On the other hand, capitation and per case payment methods for physicians and hospitals raise questions about potential underuse—the failure to provide services from which the patient would likely benefit. Indeed, no payment method perfectly aligns financial incentives with the goal of quality improvement for all health care decision makers, including clinicians, hospitals, and patients. This is one reason for the widespread interest in blended methods of payment designed to counter the disadvantages of one payment method with the advantages of another.

Too little attention has been paid to the careful analysis and alignment of payment incentives with quality improvement. The current health care environment is replete with examples of payment policies that work against the efforts of clinicians, health care administrators, and others to improve quality. The following example, presented at an Institute of Medicine workshop on payment and quality held on April 24, 2000,<sup>2</sup> illustrates how payment policies can work against the efforts of clinicians, health care administrators, and others to improve quality:

A physician group paid primarily on a fee-for-service basis instituted a new program to improve blood sugar control for diabetic patients. Specifically, pilot studies suggested that tighter diabetic management could decrease hemoglobin A1c levels by 2 percentage points for about 40 percent of all diabetic patients managed by the physician group. Data from two randomized controlled trials demonstrated that better sugar controls should translate into lower rates of retinopathy, nephropathy, peripheral neurological damage, and heart disease. The

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<sup>2</sup> This case study has been excerpted from a paper prepared by and presented at the IOM workshop by Brent James, Intermountain Health Care, Salt Lake City, Utah, April 2000.

savings in direct health care costs (i.e., reduced visits and hospital episodes) from avoided complications have been estimated to generate a net savings of about \$2,000 per patient per year, on average, over 15 years. Across the more than 13,000 diabetic patients managed by the physician group, the project had the potential to generate over \$10 million in net savings each year. The project was costly to the medical group in two ways. First, expenses to conduct the project, including extra clinical time for tighter management, fell to the physician group. Second, over time, as diabetic complication rates fell, the project would reduce patient visits and, thus, revenues as well. But the savings from avoided complications would accrue to the insurer or a self-funded purchaser.

The committee believes that all purchasers, both public and private, should carefully reexamine their payment policies.

**Recommendation 10: Private and public purchasers should examine their current payment methods to remove barriers that currently impede quality improvement, and to build in stronger incentives for quality enhancement.**

Payment methods should:

- Provide fair payment for good clinical management of the types of patients seen. Clinicians should be adequately compensated for taking good care of all types of patients, neither gaining nor losing financially for caring for sicker patients or those with more complicated conditions. The risk of random incidence of disease in the population should reside with a larger risk pool, whether that be large groups of providers, health plans, or insurance companies.
- Provide an opportunity for providers to share in the benefits of quality improvement. Rewards should be located close to the level at which the re-engineering and process redesign needed to improve quality are likely to take place.
- Provide the opportunity for consumers and purchasers to recognize quality differences in health care and direct their decisions accordingly. In particular, consumers need to have good information on quality and the ability to use that information as they see fit to meet their needs.
- Align financial incentives with the implementation of care processes based on best practices and the achievement of better patient outcomes. Substantial improvements in quality are most likely to be obtained when providers are highly motivated and rewarded for carefully designing and fine-tuning care processes to achieve increasingly higher levels of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.
- Reduce fragmentation of care. Payment methods should not pose a barrier to providers' ability to coordinate care for patients across settings and over time.

To assist purchasers in the redesign of payment policy based on these fundamental principles, a vigorous program of pilot testing and evaluating alternative design options should be pursued.

**Recommendation 11: The Health Care Financing Administration and the Agency for Healthcare Research and Quality, with input from private payers, health care organizations, and clinicians, should develop a research agenda to identify, pilot test, and evaluate various options for better aligning current payment methods with quality improvement goals.**

Examples of possible means of achieving this end include blended methods of payment for providers, multiyear contracts, payment modifications to encourage use of electronic interaction among clinicians and between clinicians and patients, risk adjustment, bundled payments for priority conditions, and alternative approaches for addressing the capital investments needed to improve quality.

### *Preparing the Workforce*

A major challenge in transitioning to the health care system of the 21st century envisioned by the committee is preparing the workforce to acquire new skills and adopt new ways of relating to patients and each other. At least three approaches can be taken to support the workforce in this transition. One is to redesign the way health professionals are trained to emphasize the aims for improvement set forth earlier, including teaching evidence-based practice and using multidisciplinary approaches. Second is to modify the ways in which health professionals are regulated to facilitate the needed changes in care delivery. Scope-of-practice acts and other workforce regulations need to allow for innovation in the use of all types of clinicians to meet patient needs in the most effective and efficient way possible. Third is to examine how the liability system can constructively support changes in care delivery while remaining part of an overall approach to accountability for health care professionals and organizations. All three approaches are important and require additional study.

**Recommendation 12: A multidisciplinary summit of leaders within the health professions should be held to discuss and develop strategies for (1) restructuring clinical education to be consistent with the principles of the 21st-century health system throughout the continuum of undergraduate, graduate, and continuing education for medical, nursing, and other professional training programs; and (2) assessing the implications of these changes for provider credentialing programs, funding, and sponsorship of education programs for health professionals.**

**Recommendation 13: The Agency for Healthcare Research and Quality should fund research to evaluate how the current regulatory and legal systems (1) facilitate or inhibit the changes needed for the 21st-century health care delivery system, and (2) can be modified to support health care professionals and organizations that seek to accomplish the six aims set forth in Chapter 2.**

## SUMMARY

The changes needed to realize a substantial improvement in health care involve the health care system as a whole. The new rules set forth in this report will affect the role, self-image, and work of front-line doctors, nurses, and all other staff. The needed new infrastructures will challenge today's health care leaders—both clinical leaders and management. The necessary environmental changes will require the interest and commitment of payers, health plans, government officials, and regulatory and accrediting bodies. New skills will require new approaches by professional educators. The 21st-century health care system envisioned by the committee—providing care that is evidence-based, patient-centered, and systems-oriented—also implies new roles and responsibilities for patients and their families, who must become more aware, more participative, and more demanding in a care system that should be meeting their needs. And all involved must be united by the overarching purpose of reducing the burden of illness, injury, and disability in our nation.

American health care is beset by serious problems, but they are not intractable. Perfect care may be a long way off, but much better care is within our grasp. The committee envisions a system that uses the best knowledge, that is focused intensely on patients, and that works across health care providers and settings. Taking advantage of new information technologies will be an important catalyst to moving us beyond where we are today. The committee believes that achieving such a system is both possible and necessary.

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# CROSSING THE QUALITY CHASM

## **A New Health System for the 21st Century**

Committee on Quality of Health Care in America

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The serpent has been a symbol of long life, healing, and knowledge among almost all cultures and religions since the beginning of recorded history. The serpent adopted as a logotype by the Institute of Medicine is a relief carving from ancient Greece, now held by the Staatliche Museen in Berlin.

*“Knowing is not enough; we must apply.  
Willing is not enough; we must do.”*

—Goethe



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**Shaping the Future for Health**

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The report was reviewed by individuals chosen for their diverse perspectives and technical expertise in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments to assist the authors and the Institute of Medicine in making the published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The content of the review comments and the draft manuscript remain confidential to protect the integrity of the deliberative process. The committee wishes to thank the following individuals for their participation in the report review process:

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Although the reviewers listed above have provided many constructive comments and suggestions, they were not asked to endorse the conclusions or recommendations nor did they see the final draft of the report before its release. The review of this report was overseen by **WILLIAM H. DANFORTH**, Washington University, St. Louis, Missouri, and **EDWARD B. PERRIN**, University of Washington and VA Puget Sound Health Care System, Seattle, Washington. Appointed by the National Research Council and the Institute of Medicine, they were responsible for making certain that an independent examination of this report was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this report rests entirely with the authoring committee and the institution.

## Preface

This is the second and final report of the Committee on the Quality of Health Care in America, which was appointed in 1998 to identify strategies for achieving a substantial improvement in the quality of health care delivered to Americans. The committee's first report, *To Err Is Human: Building a Safer Health System*, was released in 1999 and focused on a specific quality concern—patient safety. This second report focuses more broadly on how the health care delivery system can be designed to innovate and improve care.

This report does not recommend specific organizational approaches to achieve the aims set forth. Rather than being an organizational construct, redesign refers to a new perspective on the purpose and aims of the health care system, how patients and their clinicians should relate, and how care processes can be designed to optimize responsiveness to patient needs. The principles and guidance for redesign that are offered in this report represent fundamental changes in the way the system meets the needs of the people it serves.

Redesign is not aimed only at the health care organizations and professionals that comprise the delivery system. Change is also required in the structures and processes of the environment in which those organizations and professionals function. Such change includes setting national priorities for improvement, creating better methods for disseminating and applying knowledge to practice, fostering the use of information technology in clinical care, creating payment policies that encourage innovation and reward improvement in performance, and enhancing educational programs to strengthen the health care workforce.

The Quality of Health Care in America project is supported largely by the income from an endowment established within the Institute of Medicine by the

Howard Hughes Medical Institute and income from an endowment established for the National Research Council by the W. K. Kellogg Foundation. Generous support was provided by the Commonwealth Fund for a workshop on applying information technology to improve the quality of clinical care, by the Health Care Financing Administration for a workshop aimed at exploring the relationship between payment policy and quality improvement, by the Robert Wood Johnson Foundation for a survey of exemplary systems of care, by the California Health Care Foundation for a workshop to explore methods for communicating with the public about quality in health care, and by the Agency for Healthcare Research and Quality for a workshop on the relationship between patient outcomes and provider volume.

Although the committee takes full responsibility for the content of this report, many people have made important contributions. The Subcommittee on Designing the Health System of the 21st Century, under the direction of Donald Berwick, combined a depth of knowledge and creativity to propose a vision on how health care could be delivered in the 21st century. The Subcommittee on Creating an External Environment for Quality, under the direction of J. Cris Bisgard and Molly Joel Coye, provided expert guidance and a wealth of experience on how the external environment could support improved delivery of care. Lastly, the IOM staff, under the direction of Janet Corrigan, have provided excellent research, analysis and writing.

Now is the right time for the changes proposed in this report. Technological advances make it possible to accomplish things today that were impossible only a few years ago. Patients, health care professionals, and policy makers are becoming all too painfully aware of the shortcomings of our current care delivery systems and the importance of finding better approaches to meeting the health care needs of all Americans. The committee does not offer a simple prescription, but a vision of what is possible and the path that can be taken. It will not be an easy road, but it will be most worthwhile.

William C. Richardson, Ph.D.  
*Chair*  
March 2001

## Foreword

This is the second and final report of the Committee on the Quality of Health Care in America. Response to the committee's first report, *To Err is Human: Building a Safer Health System*, has been swift, positive, and ongoing from many health care organizations, practitioners, researchers, and policy makers.

The present report addresses quality-related issues more broadly, providing a strategic direction for redesigning the health care delivery system of the 21st century. Fundamental reform of health care is needed to ensure that all Americans receive care that is safe, effective, patient centered, timely, efficient, and equitable.

As this report is being released, we are reflecting on the recent loss of a great 20th-century leader in the field of health care quality. Avedis Donabedian, member of the Institute of Medicine, leaves behind a rich body of work on the conceptualization and measurement of quality. His extraordinary intellectual contributions will continue to guide efforts to improve quality well into the coming century.

The Quality of Health Care in America project continues the Institute of Medicine's long-standing focus on quality-of-care issues. The Institute's National Roundtable on Health Care Quality has described the variability of the quality of health care in the United States and highlighted the urgent need for improvement. The report *Ensuring Quality Cancer Care* issued by the Institute's National Cancer Policy Board, offers the conclusion that there is a wide gulf between ideal cancer care and the reality experienced by many Americans. And a forthcoming report from the Institute's Committee on the National Quality

Report on Health Care Delivery will offer a framework for periodic reporting to the nation on the state of quality of care.

This report reinforces the conviction of these and other concerned groups that we cannot wait any longer to address the serious quality-of-care challenges facing our nation. A comprehensive and strong response is needed now.

Kenneth I. Shine, M.D.  
*President, Institute of Medicine*  
March 2001

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In addition, a number of people willingly and generously contributed their time and expertise as the committee and both subcommittees conducted their deliberations.

**The planning committee for the Workshop on Using Information Technology to Improve the Quality of Care** did an excellent job of organizing the workshop. This committee consisted of E. Andrew Balas, University of Missouri School of Medicine; Don E. Detmer, University of Cambridge; Jerome H. Grossman, John F. Kennedy School of Government, Harvard University; and Brent James, Intermountain Health Care. **The participants in this workshop** provided a great deal of useful information that is reflected in this report. These participants were E. Andrew Balas, University of Missouri School of Medicine; David W. Bates, Brigham Internal Medicine Associates; Mark Braunstein, Patient Care Technologies; Charles R. Buck, General Electric Company; Maj. Gen. Paul K. Carlton, Jr., Air Force Medical Operations Agency; David C. Classen, University of Utah; Paul D. Clayton, Intermountain Health Care; Kathryn L. Coltin, Harvard Pilgrim Health Care; Louis H. Diamond, The MEDSTAT Group; J. Michael Fitzmaurice, Agency for Health Care Policy and Research; Janlori Goldman, Georgetown University; Jerome H. Grossman, John F. Kennedy School of Government, Harvard University; David Gustafson, University of Wisconsin-Madison; Betsy L. Humphreys, U.S. National Library of Medicine; Brent James, Intermountain Health Care; John T. Kelly, AETNA/U.S. Healthcare; David B. Kendall, Progressive Policy Institute; Robert Kolodner, Department of Veterans Affairs; George D. Lundberg, Northwestern University; Robert Mayes, Health Care Financing Administration; Ned McCulloch, IBM, formerly Office of Senator Joseph Lieberman; Elizabeth A. McGlynn, The RAND Corporation; Blackford Middleton, MedicaLogic; Gregg S. Meyer, Agency for Health Care Policy and Research; Arnold Milstein, Pacific Business Group on Health; Donald Moran, The Moran Company; Michael Nerlich, University of Regensburg; William C. Richardson, W. K. Kellogg Foundation; Richard D. Rubin, Foundation for Health Care Quality; Charles Saunders, Healtheon/WebMD; Joseph E. Scherger, University of California, Irvine; Kenneth Smithson, VHA, Inc.; William W. Stead, Vanderbilt University; Stuart Sugarman, Mount Sinai/NYU Health; Paul C. Tang,

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# CROSSING THE QUALITY CHASM



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# An Action Plan for Behavioral Health Workforce Development



Persons in Recovery  
& Families  
Community Capacity



Recruitment &  
Retention  
Training & Education



Leadership  
Infrastructure  
Research & Evaluation

## A Framework for Discussion

## Executive Summary



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The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA or DHHS.

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**2007**



# EXECUTIVE SUMMARY

## INTRODUCTION AND OVERVIEW

### **A Workforce Crisis**

Across the nation there is a high degree of concern about the state of the behavioral health workforce and pessimism about its future. Workforce problems have an impact on almost every aspect of prevention and treatment across all sectors of the diverse behavioral health field. The issues encompass difficulties in recruiting and retaining staff, the absence of career ladders for employees, marginal wages and benefits, limited access to relevant and effective training, the erosion of supervision, a vacuum with respect to future leaders, and financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources.

Most critically, there are significant concerns about the capability of the workforce to provide quality care. The majority of the workforce is uninformed about and unengaged in health promotion and prevention activities. Too many in the workforce also lack familiarity with resilience- and recovery-oriented practices and are generally reluctant to engage children, youth, and adults, and their families, in collaborative relationships that involve shared decision-making about treatment options. It takes well over a decade for proven interventions to make their way into practice, since prevention and treatment services are driven more by tradition than by science. The workforce lacks the racial diversity of the populations it serves and is far too often insensitive to the needs of individuals, as these are affected by ethnicity, culture, and language. In large sections of rural America, there simply is no mental health or addictions workforce.

There is overwhelming evidence that the behavioral health workforce is not equipped in skills or in numbers to respond adequately to the changing needs of the American population. While the incidence of co-occurring mental and addictive disorders among individuals has increased dramatically, most of the workforce lacks the array of skills needed to assess and treat persons with these co-occurring conditions. Training and education programs largely have ignored the need to alter their curricula to address this problem and, thus, the nation continues to prepare new members of the workforce who simply are underprepared from the moment they complete their training.

It is difficult to overstate the magnitude of the workforce crisis in behavioral health. The vast majority of resources dedicated to helping individuals with mental health and substance use problems are *human resources*, estimated at over 80% of all expenditures (Blankertz & Robinson, 1997a). As this report documents in its complete version, there is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and is largely unable to deliver care of proven effectiveness in partnership with the people who need services. There is equally compelling evidence of an anemic pipeline of new recruits to meet the complex behavioral health needs of the growing and increasingly diverse population in this country. The improvement of care and the transformation of systems of care depend entirely on a workforce that is adequate in size and effectively trained and supported. Urgent attention to this crisis is essential.

### **An Action Plan with National Scope**

This Executive Summary gives an overview of key findings of a multiyear process that led to this Action Plan for strengthening the behavioral health workforce. In order to address the workforce crisis described above, the Substance Abuse and Mental Health Services Administration (SAMHSA) commissioned the Annapolis Coalition on the Behavioral Health Workforce ([www.annapoliscoalition.org](http://www.annapoliscoalition.org)) to develop an Action Plan on workforce development that encompasses the breadth of this field and is national in scope. The planning process was funded by the SAMHSA Office of the Administrator and all three centers within the federal agency: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT), and the Center for Substance Abuse Prevention (CSAP). The planning process was intended to build on previous workforce planning efforts, including the CSAT-sponsored report on *Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce* (U.S. Department of Health and Human Services [DHHS], 2005a).

The Annapolis Coalition is a not-for-profit organization focused on improving workforce development in the mental health and addiction sectors of the behavioral health field. Since 2000, the Coalition has functioned as a neutral convener of diverse individuals, groups, and organizations that recruit, train, employ, license, and receive services from the workforce (Hoge & Morris, 2002; Hoge & Morris, 2004; Hoge, Morris, & Paris, 2005). The Coalition conducts strategic planning, identifies innovation, and has provided technical assistance in workforce issues to federal and state agencies, private organizations, and commissions, including the New Freedom Commission on Mental Health (2003) and the Institute of Medicine (IOM, 2006).

This strategic planning process was designed to examine current weaknesses in efforts to develop and sustain a strong workforce in behavioral health; develop a vision for a future workforce that is

compassionate, effective, and efficient; and identify practical strategies that can be implemented to achieve that vision. Because federal powers largely have shifted to state and local governments, and all governments increasingly are turning to private organizations as vehicles for action (Bryson, 2004), this Action Plan is intended to demonstrate how public and private collaboration by diverse stakeholders can strengthen the behavioral health workforce. The ultimate aim of these efforts is to improve dramatically the quality of care received by individuals and their families who are served by behavioral health care providers.

## **Areas of Focus**

From a population perspective, this Action Plan encompasses workforce issues relevant to persons with mental health conditions, substance abuse or substance use disorders, and co-occurring mental and addictive conditions. A life-span perspective was adopted to ensure that the planning process gave specific attention to workforce development issues pertaining to children, youth, and parents, as well as older adults. Planning also was organized around the workforce needs related to culturally and linguistically diverse populations, as well as those living and working in rural and frontier areas.

With respect to workforce activities, the planning process examined health promotion, prevention, treatment, rehabilitation, recovery, and resilience-oriented approaches. It also examined the continuum of behavioral health needs, from mild problems to severe and persistent illnesses. A range of other workforce activities and processes required and received attention, including recruitment and retention, training and education, licensure and certification, workforce financing, and the use of information technology in training and service delivery.

## **Defining the Workforce**

A broad definition of workforce was adopted for this planning process. It included the behavioral health workforce, consisting of individuals in training or currently employed to provide health promotion, prevention, and treatment services. This group includes professionals with graduate training, as well as individuals who have associate's or bachelor's degrees, high school diplomas, or even less formal education.

Persons in recovery and their family members are explicitly recognized as pivotal members of the workforce, as they have critical roles in caring for themselves and each other, whether informally through self-help and family caregiving or more formally through organized peer- and family-support services. These individuals are the unsung heroes and heroines of the workforce and provide a unique perspective that enhances the overall relevance and value of the care provided. While other health and human

service providers, such as primary care providers, emergency room staff, correctional staff, and teachers, have major roles in responding to the needs of individuals with mental and addictive disorders, these segments of the workforce were not addressed in this planning process due to time and resource constraints. Their critical role in the informal behavioral health workforce is acknowledged and their workforce development needs unquestionably warrant attention in a subsequent planning effort.

## Issues of Language

Even when individuals speak the same language there are barriers to communication. One of the special challenges in developing a broadly inclusive strategic plan involved grappling with variations in terminology used by stakeholders representing the highly diverse areas in this field. The selection and use of language is an extremely important issue. However, there is a lack of consensus on terms that are broadly applicable and acceptable to all of the individuals, organizations, interests, and issues that constitute the field. The authors of this report made extensive efforts to find and use language that would be generally relevant and acceptable to all readers and nonstigmatizing to individuals and families; at the same time, the authors recognize that many of the terms used within these pages are imprecise and imperfect.

## A Common Agenda

The behavioral health field has not historically spoken with one voice. As recommendations emerged from the panels and work groups formed to conduct the action planning, there often was controversy. But as the discussions progressed, as language differences were explored and resolved, and as assumptions were probed and made transparent, it became clear that there are many commonalities regarding workforce issues across the various sectors of this field. It also became abundantly clear that the people working in these diverse sectors have much to learn from each other and much to be gained by working together on a common workforce agenda.

The objective of the planning process was to examine workforce issues broadly across the behavioral health field in order to identify a set of *core*, *common* or *cross-cutting* goals and objectives that have broad relevance to all sectors of the field. This Action Plan was not intended to be, nor can it function as, the definitive and detailed plan for a specific sector, population, government agency, or private organization. However, it is designed to serve as a resource that can inform, focus, and help guide any agency, organization, or sector of the field as it devises a detailed action plan tailored to its specific history, needs, and current priorities. In fact, the value of this planning effort rests on the assumption that a broad array of stakeholders will move the workforce development agenda forward in their own spheres of influence, informed by the recommendations of their peers as outlined in this report.

While more than 5,000 individuals were involved in this planning process, there undoubtedly are many individuals who have opinions on these issues who did not have the opportunity to contribute. This Action Plan is considered a work in progress that must continue to evolve as others add their voices, as the health care environment continues to change, as more experience is gained with the recommendations, and as better evidence is generated about effective strategies to strengthen the workforce.

## THE PLANNING PROCESS

Given the intended breadth of this Action Plan and the need for multiple methods of data collection, an array of planning vehicles was adopted. Nationally recognized experts in workforce development from diverse sectors of the field were engaged as senior and technical advisors to manage planning in their respective areas of expertise, to function as emissaries in this process to their peers, and to serve on the National Steering Committee of the Annapolis Coalition, which reviewed and vetted all recommendations and the content of the final report. The advisors convened and chaired 12 expert panels and work groups, which were responsible for reviewing prior workforce reports and recommendations; obtaining input from colleagues via professional meetings and planning sessions conducted across the country; identifying workforce development innovations; and formulating a set of proposed goals, objectives, and actions. Expert panels were generally larger in membership or had a longer life span than the work groups. The panels and work groups were as follows:

- Child, Adolescent, & Family Panel
- School-based Mental Health Panel
- Consumer & Family Panel/Adult Mental Health
- Cultural Competency & Disparity Panel
- Substance Use Disorders Treatment Panel
- Substance Abuse Prevention Panel
- Older Adults Panel
- Rural Panel
- Provider Accreditation Panel
- Educators Work Group
- Information Technology/Distance-Learning Work Group
- Financing Work Group

The Annapolis Coalition issued an open call for submission of information and recommendations via the Internet and extended specific invitations to a wide range of groups and organizations through a variety of

mechanisms. Recommendations submitted through all sources were organized into seven goal areas, which were expanded into detailed implementation tables, clustered around the specific objectives necessary to achieving each goal. These implementation plans, along with the text developed to explain the recommendations, were reviewed and revised by the National Steering Committee. Senior and technical advisors then drafted additional sections of the report that focused on their sector, population, or other area of expertise. The draft report was vetted through a national conference held by SAMHSA in July of 2006 with more than 200 participants drawn from all sectors of the field. Modifications to the report were made based on feedback from participants.

For a strategic plan that is national in scope to have credibility it must attend to the critical issues of both content and process. Within the time and resource constraints of this endeavor, achieving broad participation and wide-ranging input (grounded in a thorough review of available reports and the published workforce literature) were of paramount importance. With respect to process, a conservative estimate is that more than 5,000 individuals were engaged in some way in contributing to this planning process, with every individual specifically invited to provide verbal or written input. The credit for the thoroughness and quality of the final report belongs to the many individuals who contributed to the process. The Annapolis Coalition accepts responsibility for any limitations, errors, or omissions in the final report.

The planning process resulted in an overview of the workforce and the environment in which it functions; general findings about the characteristics of the workforce crisis; and a set of seven strategic goals, accompanied by specific objectives and recommended actions necessary to achieve these goals. The following sections provide summaries of these topics.

## THE CURRENT WORKFORCE AND ITS ENVIRONMENT

### **The Mental Health Workforce**

Historically, neither state agencies nor professional associations have collected information routinely on the workforce using a standardized data set or common schedule. Thus it has been difficult to assemble a unified picture of the mental health workforce or to compare the various disciplines that constitute it. The Alliance of Mental Health Professions has been developing a standardized data set and working to generate comparable data across disciplines (Duffy et al., 2004). However, further progress on this agenda is sorely needed.

The best available estimates indicate that there were slightly more than a half million clinically trained and active mental health professionals in the United States in 2002 (Manderscheid & Henderson, 2004).

There are differing trends regarding the growth rates of the various disciplines within the field, with psychiatry essentially static in terms of growth, psychology doubling in size over the past 25 years, and social work increasing by 20% over the past 1 ½ decades. Increases in the number of psychiatric nurses with graduate-level preparation largely have been offset by the number of nurses leaving the active workforce and by sharp reductions in the number of students who are enrolling in this discipline's graduate programs.

There is a notable lack of racial and cultural diversity among the mental health disciplines. The vast majority of professionals are non-Hispanic Whites, often exceeding 90% of discipline composition (Duffy et al., 2004). For most disciplines, substantially more than half of the clinically trained professionals are over the age of 50, raising serious concerns about whether the pipeline of young professionals will be adequate to compensate for both the growing service demand and the approaching retirement of large segments of the workforce (Duffy et al., 2004).

Compounding concerns about workforce size are problems with its geographic distribution. Holzer, Goldsmith, and Ciarlo (2000) provide evidence that the heaviest concentrations of highly trained professionals are in urban centers. In fact, more than 85% of the 1,669 federally designated mental health shortage areas are rural in nature (Bird, Dempsey, & Hartley, 2001). Half of the counties in the United States do not have a single mental health professional.

In addition to graduate degreed professionals, there are 145,000 members of the mental health workforce who do not have graduate-level professional training but rather possess a bachelor's degree or less (Morris & Stuart, 2002). This segment of the workforce includes registered nurses, bachelor's-prepared social workers, and various technicians or aides. This group of individuals too seldom receives systematic training and support despite the fact that it accounts for up to 40% of the workforce in many public-sector service settings.

### **The Substance Use Disorders Treatment Workforce**

The workforce that is specifically trained and credentialed to provide substance use disorders services is small in comparison to the identified need. Only 1 person in 10 who has a drug use disorder and 1 person in 20 who has an alcohol use disorder receive treatment for the condition (Wright, 2004). The workforce implications of these statistics are simply staggering.

An estimated 67,000 licensed and unlicensed counselors provide substance use disorder treatment and related services (Harwood, 2002). An additional 40,000 professionals are licensed or credentialed to provide such care (Keller & Dermatis, 1999). These professionals are predominately social workers,

complemented by small contingents from general medicine, psychiatry, psychology, nursing, and marriage and family therapy.

The substance use disorders treatment workforce is primarily female, older, and White. For example, among new counselors entering the field, 70 percent are female (NAADAC, 2003). The average age of treatment staff is mid-forties to early fifties (NAADAC, 2003; RMC, 2003). Studies indicate that from 70 percent to 90 percent of substance use disorder treatment personnel are Caucasian (Harwood, 2002; Knudsen, Johnson, & Roman, 2003; Mulvey, Hubbard, & Hayashi, 2003; RMC, 2003). The characteristics of staff working in this sector of the field frequently differ from their predominantly young, male, and minority clientele.

### **The Substance Abuse Prevention Workforce**

The workforce in substance abuse prevention has been estimated at ½ million in number. However, there is no standard inventory or methodology for defining and counting this sector of the workforce. In terms of composition, it includes professionals from the fields of social work, education, psychology, criminal justice, health care, counseling, and the clergy. This workforce also includes parents, teachers, youth leaders, indigenous workers, law enforcement officers, school personnel, and civic and volunteer groups, often organized as community coalitions ([www.cadca.org](http://www.cadca.org)).

The substance abuse prevention workforce typically falls into three distinct yet overlapping subgroups: (1) tribal, state, territory, or substate managers of prevention funding and delivery systems; (2) direct implementers of prevention programs and activities; and (3) community or coalition members engaged in promoting behavioral health and wellness in their communities. Some members of this prevention workforce have obtained state credentialing in addictions, while many others have chosen not to pursue or are not eligible for credentialing due to the educational prerequisites.

### **The Environment of Care**

Each day, environmental forces shape, promote, challenge, block, or defeat the activities of the workforce and thus heavily influence how well the behavioral health needs of individuals, families, and communities are met. A well-prepared workforce has little meaning in an environment that does not actively support its values or effective practice, or offer employees competitive wages and benefits. As noted by an expert in the field of human performance, “When you pit a bad system against a good performer, the system almost always wins” (Rummler, 2004).

With respect to service delivery, both organizational and system characteristics are at least as influential as the education and training of individual personnel (IOM, 2001, 2004). Throughout the planning process, participants repeatedly expressed concerns that the health care environment is actually “toxic” to adults in recovery, to children and youth, to their families, and to the workforce that strives to provide prevention and treatment services.

A broad range of other environmental issues has a negative impact on the workforce. It has been frequently reported that staffing levels are reduced as a cost-cutting measure, while patient caseloads and acuity levels increase. Financing mechanisms and organizational constraints create conflict for the provider who is asked to be responsive to the bottom line of his or her organization but, in so doing, may jeopardize the interests of the individuals in need of care (Wolff & Schlesinger, 2002).

Members of the workforce routinely struggle with the ambiguity of the rules, regulations, standards, and procedures that govern service delivery, and which sometimes conflict with one another. These rules may not be grounded in an evidence base. They often limit professional judgment, and can constrain efforts to tailor interventions to individual need. Productivity is reduced because of administrative burdens, most notably those involving extensive and often repetitive documentation. Members of the workforce have repeatedly described their low morale and low levels of commitment to their organization and to the field because of low pay, the absence of career ladders, excessive workloads, tenuous job security, the lack of supervision, and an inability to influence the organization or system in which they are working (Blankertz & Robinson, 1997b; Center for Health Workforce Studies, 2006; Gellis & Kim, 2004; Hanrahan & Gerolamo, 2004; IOM, 2003, 2004; Zurn, Dal Poz, Stilwell, & Adams, 2004).

In recent reports on the addiction treatment workforce, CSAT (DHHS, 2003, 2005b) identified several conditions and trends that have broad relevance for the workforce in all sectors of behavioral health. These include:

- A workforce and treatment capacity insufficient to meet demand.
- A changing profile of the people in need of services, which includes increased co-occurring mental illnesses and substance use disorders, medical comorbidity, rapidly evolving patterns of licit and illicit drug use, and involvement in the criminal justice system.
- A shift to increased public financing of treatment, accompanied by declining private coverage, budgetary constraints in publicly funded systems, managed care policies and practices, and the large number of undocumented and uninsured individuals.
- Major paradigm shifts within the field, including the movement toward a recovery management (and resilience-oriented) model of care.

- A continual escalation of demands on workers to change their practices, including the adoption of best practices and evidence-based interventions.
- An increase in the use of medications in treatment, with the resultant demand that the workforce be knowledgeable and skilled in managing medications.
- A challenge to provide services more frequently in nonbehavioral health settings.
- An expansion of requirements to implement performance measures and to demonstrate patient outcomes through data.
- A climate of ongoing discrimination or stigma related to people who receive *and* provide care.

Perhaps no change has as much impact on the workforce as the emerging redefinition of the role of the consumer in making health care decisions. This is as true in behavioral health as it is in general medicine. Trends such as illness self-management, peer-support approaches, and increased access to information via the Internet are remodeling the relationships among practitioners, patients, and their families, thus posing new challenges for the workforce as well as new opportunities for genuine partnerships between consumer and provider in the decision-making process (Morris & Stuart, 2002).

## GENERAL FINDINGS

Workforce problems are evident in every element or dimension of the behavioral health field. Concerns about the workforce also exist among every group of stakeholders concerned about the future of prevention and treatment for mental health and substance use problems. General findings about the workforce crisis are described below, and are treated in depth in the larger report.

There is a critical shortage of individuals trained to meet the needs of children and youth, and their families. As just one example, the federal government has projected the need for 12,624 child and adolescent psychiatrists by 2020, far exceeding the projected supply of 8,312. Currently there are only 6,300 such psychiatrists nationwide, and relatively few are located in rural and low-income areas (American Academy of Child and Adolescent Psychiatry [AACAP] Task Force, 2001). There is an even more severe shortage of practitioners trained and credentialed to treat adolescents with substance use disorders.

Only five states require adolescent-specific knowledge for licensure (Pollio, 2002). Furthermore, behavioral health professionals who have been trained to provide behavioral health prevention and intervention in the nation's schools are in significantly short supply, or are hindered by the constraints of their position to use such skills. Beyond the issue of workforce size, the training programs that do focus on prevention and treatment for children and youth, and their families, have not kept pace with current

trends in the field, which have been shifting toward strengths-based and resilience-oriented models, a systems-of-care approach, and the use of evidence-based practices (Curie, Brounstein, & Davis, 2004; McLellan & Meyers, 2004; Meyers, Kaufman, & Goldman, 1999).

There is a pronounced shortfall in the current workforce of providers with expertise in geriatrics, and this deficit is expected to worsen. Only 700 practicing psychologists view older adults as their principal population of focus, well short of the estimated 5,000 to 7,500 geropsychologists necessary to meet current needs (Jeste et al., 1999). Similarly, only 640 members of the American Psychiatric Nurses Association (APNA, 2002) have a subspecialization in geriatrics. In 2001, there were only 81 geriatric psychiatry fellows in training in this nation, and 39% of the available fellowships went unfilled (Warshaw, Bragg, Shaull, & Lindsell, 2002). These numbers suggest that creating more training opportunities may be a necessary, yet insufficient, workforce strategy.

As described in the introduction to this report, only 20% of the individuals in this country who need substance use disorders treatment each year receive it. This is due, in part, to severe difficulties in recruiting and retaining qualified staff in sufficient numbers (Gallon, Gabriel, & Knudsen, 2003; Hall & Hall, 2002; Northeast Addiction Technology Transfer Center, 2005). In the most compelling study of this issue, McLellan, Carise, and Kleber (2003) found a 50% turnover in frontline staff *and* directors of substance use disorder treatment agencies in a single year. Furthermore, 70% of the frontline staff members in these agencies did not have access to basic information technology to support their daily work.

In rural America, the workforce crisis is particularly acute. More than 85% of the 1,669 federally designated mental health professional shortage areas are rural (Bird, Dempsey, & Hartley, 2001), and they typically lack even a single professional working in the mental health disciplines. It has been extraordinarily difficult to recruit, train, and retain professionals in rural areas. Traditional approaches to workforce development center on “programs and professionals” and often fail to address local needs. Few training programs offer any significant focus on rural behavioral health service delivery.

Workforce distribution issues relate not only to geography but also to race and culture. U.S. Census figures indicate that 30% of the nation's population is drawn from four major ethnic groups: Latinos, African Americans, Asian American/Pacific Islanders, and Native Americans. However, the behavioral health workforce lacks such cultural diversity, particularly in mental health. For example, non-Hispanic Whites currently account for 75.7% of all psychiatrists, 94.7% of psychologists, 85.1% of social workers, 80% of counselors, 91.5% of marriage and family therapists, 95.1% of school psychologists, and 90.2% of psychiatric nurses (Duffy et al., 2004). Cross-cultural training has the potential to improve quality of

care and service use among people of color (Fortier & Bishop, 2003), but the workforce at large cannot be characterized as culturally or linguistically competent.

Workforce issues are a personal matter for individuals with mental health and substance use problems. While the experiences of those who receive care vary greatly, the individuals whose voices were heard during the process of compiling this Action Plan were, by and large, very dissatisfied with the workforce. There was considerable anger about what many of these individuals described as the stigmatizing attitudes among the workforce about persons with mental and addictive disorders. Other complaints about the workforce focused on inadequate understanding and support for recovery- and resilience-oriented approaches to care and a basic lack of empathy and compassion. These complaints should be of deep concern to the field, given the importance of therapeutic relationships as a basic foundation for all efforts to care effectively for people in need.

Another group that voiced strong concerns comprised managers within organizations that employ the workforce. Their constant lament was that recent graduates of professional training programs are unprepared for the realities of practice in real-world settings, or worse, have to unlearn an array of attitudes, assumptions, and practices developed during graduate training that hinder their ability to function. In an era of scarce resources, the specter of education and training programs that lack relevance to the needs of the American population and to current prevention and treatment approaches raises considerable alarm.

As in general health care, the delay in translating science into services is a major concern in behavioral health. Within the workforce, the change in practice patterns appears to occur with the changing generations of treatment providers and prevention specialists. Underlying this troubling dynamic is the fact that educational systems emphasize the teaching of specific practices. Their focus is typically on teaching “content” as opposed to teaching and instilling in students a “process” of continuous, lifelong, real-world learning.

Training in behavioral health now occurs in disciplinary or sector silos. Furthermore, there is little collaboration among the disciplines on workforce development efforts, such as competency development, despite the presence of many shared competencies across professions. Three other tensions impede cooperation on a strengthened national workforce development agenda or dissemination of workforce innovations across sectors and disciplines: the divide between the mental health and addiction portions of the field; the split between treatment and prevention that exists within mental health and within addictions; and, in all sectors, the separation between the traditional treatment system and the recovery community.

There is a striking lack of data, not only about the workforce but also about workforce development practices. The scattered information that does exist has no uniformity, which hinders cross comparison or aggregation of the data to examine trends. The reliability of workforce data is generally open to question. There is little consensus about key workforce variables, and there are few benchmarks that organizations can use as a reference point in assessing the magnitude of their workforce problems or success in addressing them. Published studies on interventions to strengthen the workforce seldom use solid research designs and methods and are often simply anecdotal reports.

As training, prevention, and treatment organizations attempt to address workforce issues, there is a notable tendency to do what is affordable rather than what is effective. The most glaring example is the provision of single-session, didactic in-services or workshops, which are the most frequent approach to staff training and development. These are the mainstay of training efforts even though there is clear evidence of their ineffectiveness in changing practice patterns. System and agency managers are increasingly hungry for workforce tools of proven effectiveness, yet relatively few interventions or models are well described, portable, and easily adapted to different settings. There are pockets of innovation across the nation, but these are uniformly underfinanced and difficult to sustain, and are seldom disseminated or replicated in other locales; the full Action Plan includes many examples of promising innovation.

Despite the dire state of the workforce, there are a number of causes for optimism about the future. Many dedicated members of the workforce and many committed leaders in the behavioral health field understand the critical need to address seriously the many issues outlined above. The issues now are receiving federal, state, and local attention. The existing pockets of innovation are good starting points as building blocks for more comprehensive and systematic solutions to current workforce dilemmas. The field can and must move forward to tackle the workforce challenge.

## SEVEN STRATEGIC GOALS: AN OVERVIEW

The distillation of the reports and recommendations of the multiple expert panels and work groups yielded a set of seven final action goals (Table 1). Goals 1 and 2 focus on broadening the concept of workforce. Persons in recovery, children, youth, families, and communities are not simply recipients of prevention and treatment services. They are active in promoting and maintaining health and wellness, defining their unique needs, caring for themselves, supporting each other, and providing guidance about when, where, and how services should be delivered. Their roles as both formal and informal members of the behavioral health workforce must be greatly expanded. Goals 3, 4, and 5 are traditional workforce goals that focus on strengthening the workforce. The recommended objectives and actions identified for these goals reflect activities related to best practices in recruitment and retention, training and education, and

leadership development. Goals 6 and 7 involve creating improved structural supports for the workforce, such as technical assistance on workforce practices, stronger human resources departments, greater use of information technology, and a national research and evaluation initiative to yield improved information on effective workforce practices. These goals are reviewed in the sections that follow.

A set of objectives was identified for accomplishing each of the seven goals. The goals and objectives are presented in the Quick Reference Guide, which appears as an appendix of this Executive Summary. The full report of this Action Plan contains detailed Preliminary Implementation Tables that identify specific action steps for each objective, linked to potential stakeholders who could take those actions. Readers interested in adopting for their workforce development efforts the framework provided in this report should reference the implementation tables as a guide to action.

<p>TABLE 1 STRATEGIC GOALS AT A GLANCE</p>
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#### **BROADENING THE CONCEPT OF WORKFORCE**

**GOAL 1:** Significantly expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.

**GOAL 2:** Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.

#### **STRENGTHENING THE WORKFORCE**

**GOAL 3:** Implement systematic recruitment and retention strategies at the federal, state, and local levels.

**GOAL 4:** Increase the relevance, effectiveness, and accessibility of training and education.

**GOAL 5:** Actively foster leadership development among all segments of the workforce.

#### **STRUCTURES TO SUPPORT THE WORKFORCE**

**GOAL 6:** Enhance the infrastructure available to support and coordinate workforce development efforts.

**GOAL 7:** Implement a national research and evaluation agenda on behavioral health workforce development.

**GOAL 1:** Significantly expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.

From the perspective of workforce planning and development, priority attention must be given to the role that persons in recovery, children, and youth, and their families, have in caring for themselves and each other and could have in educating the traditional workforce. The amount of service provided by behavioral health professionals and other health and human services providers simply pales in comparison to the volume of self-care, peer support, and family caregiving. Individuals with mental health and addiction problems, along with their families, are a human resource that too often has been overlooked or underutilized. A core strategic goal must be to recognize these persons as part of the workforce and to develop their capacity to care for themselves and each other effectively, just as the field must attempt to strengthen the professional workforce.

Goal 1 in this Action Plan calls for a significantly expanded role for individuals in recovery and families in the workforce. Five major objectives have been identified to achieve this goal. The first is to create fully informed individuals and family members by providing better knowledge through educational supports. Shared decision-making is a second objective, to be accomplished by training individuals, families, and providers in collaborative approaches to care. Two additional objectives focus on formal roles in the workforce for persons in recovery and family members through expanded peer- and family-support services and through increased employment of these individuals as paid staff in prevention and treatment systems. As a final objective, engaging persons in recovery and family members as educators of the workforce is designed to shape the education of providers and to foster more collaborative relationships between those receiving and providing care.

Inherent in the concept of transforming mental health service systems and models of care, as called for by the President's New Freedom Commission (2003), is a shift in power. Emerging approaches to care in behavioral health involve shifts in the locus of decision making that result in more equal partnerships between persons in recovery, family members, and providers. Many individuals who participated in the development of the Action Plan considered this strategic goal, focused as it is on an expanded role for persons in recovery and family members, to have the greatest potential to transform systems of care.

**GOAL 2:** Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.

The importance and centrality of the role of communities in promoting and maintaining behavioral health and wellness was captured by Wagenaar and colleagues (1994), who stated that "[T]he community is not

simply the *site* for the intervention but the *vehicle* for change.” Expanding on this notion, it is clear that communities are the locus for defining their health needs, priorities, and strategies, which leads to a broad vision of person-centered, family-centered, and community-centered approaches to behavioral health and wellness. Communities are a key element of the workforce in a manner quite parallel to the way in which persons in recovery, children, youth, and families are core to the workforce, as described above under Goal 1.

Expanding the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness emerged as a core strategic goal, which is relevant to all sectors of behavioral health. The proposed vehicles for accomplishing this goal center around three objectives. Most critical is an expanded effort to build five core competencies in communities, related to assessment, capacity building, planning, implementation, and evaluation ([www.cadca.org](http://www.cadca.org); DHHS, 2004). A second objective involves renewed efforts to develop competencies within the behavioral health workforce related to community development and community collaboration. As a final and more immediate objective, it is recommended that every behavioral health organization formally reassess its current connections to local groups, organizations, and coalitions, and implement a plan to increase, strengthen, and diversify these ties.

In selected towns and cities, community coalitions have had a major role in identifying and addressing behavioral health needs, particularly around issues related to substance abuse. To varying degrees, behavioral health providers from all sectors of the field have supported and partnered with their host communities. There are enormous opportunities, however, for communities to build much greater capacity to promote behavioral health and wellness and to function as a critical element of the workforce, driven by their personal investment in the outcome.

**GOAL 3: Implement systematic recruitment and retention strategies at the federal, state, and local levels.**

Recruiting and retaining competent staff members in adequate numbers is a major problem for individuals managing local prevention and treatment organizations and state behavioral health systems. Qualified providers clearly are not available in sufficient numbers in some sections of the country, largely rural in nature, and for some populations, such as children, youth, and the elderly. Most organizations and systems have been unsuccessful in recruiting a culturally and linguistically diverse workforce. While stability in staffing over time is considered a cornerstone of program and treatment consistency and therapeutic relationships (Connor et al., 2003), high rates of turnover among counselors, for example, has been noted to threaten the stability of addiction counseling centers, undermine quality of care, and strain finances due to the costs associated with recruiting, hiring, and training replacements (Knudsen, Johnson, & Roman, 2003). The retention problem among the behavioral health workforce appears to

exceed that of teachers and nurses, professions considered by society to have unacceptably high rates of turnover.

A set of eight objectives has been identified to address the recruitment and retention crisis. Information and evidence on effective recruitment and retention practices must be disseminated routinely to managers in the field as a form of technical assistance. As a second objective, it is incumbent on each prevention or treatment organization to implement a data-driven continuous quality improvement process in which interventions tailored to the recruitment and retention problems that face each organization are implemented and evaluated. Expanded financial incentives are necessary in the form of training stipends, tuition assistance, and loan forgiveness. Wages and benefits must become commensurate with education, experience, and levels of responsibility if members of the workforce are to be retained. Progress on this objective should begin with closer collaboration between behavioral health systems and federal or state departments of labor, which have expertise in benchmarking wages and benefits across professions and estimating a “living wage” for each area of the country.

A comprehensive public relations campaign promoting careers in the mental health and addiction sectors should be launched. The campaign should be combined with a Web portal on careers and job opportunities that meets the needs of prospective students, employees, and employers. Formal regional partnerships should be established between behavioral health and education systems to foster a pipeline of new recruits trained in the skills that are essential and relevant to contemporary systems of care. These partnerships should map and enhance existing career ladders to ensure a progressive set of educational steps linked to advanced certification, licensure, and increased reimbursement. These are the elements of a career ladder that allow an individual to advance within a profession or field.

It is recommended that state and local organizations implement “grow-your-own” strategies to recruit and develop a more diverse and stable workforce, with a priority focus on residents of rural areas, culturally and linguistically diverse populations, persons in recovery, youth, and family members. This strategy involves engaging local residents in entry-level positions and promoting their long-term professional growth, development, and advancement within the organization or system of care. Increasing the cultural and linguistic diversity of the workforce is a specific objective that can be fostered by establishing a clearinghouse for dissemination of culturally competent practices; increasing staff development on such practices across all levels of the workforce; ensuring a critical mass of culturally competent faculty, trainers, and mentors; and developing standards and adequate reimbursement for interpreters who are trained to work in behavioral health.

Concerted efforts are required to recruit and retain a workforce in behavioral health. The wise counsel of one participant in the planning process emphasized the importance of first keeping the workers who

already are in the field, followed by efforts to improve the tactics for bringing new recruits into the field. The research on recruitment and retention reveals that individuals employed or considering employment in this field want what any person seeks: a living wage with health care benefits; opportunities to grow and advance; clarity in a job role; some autonomy and input into decisions; manageable workloads; administrative support without crushing administrative burden; basic orientation and training for assigned responsibilities; a decent and safe physical work environment; a competent and cohesive team of coworkers; the support of a supervisor, and rewards for exceptional performance. These are the core needs of the workforce that the field must strive to address.

**GOAL 4: Increase the relevance, effectiveness, and accessibility of training and education.**

In virtually every setting in which the Annapolis Coalition sought input for the Action Plan, three interrelated themes emerged: (1) The content of current training and education frequently is not relevant to contemporary prevention and treatment practices, nor is it informed by empirical evidence; (2) teaching methods often are ineffective in changing the actual practice patterns of the people being trained; and (3) access to training and education is often quite limited, particularly in rural communities and for culturally diverse populations. These concerns were expressed about preservice professional training, the initial training offered to direct-care nondegree or bachelor's-prepared staff, and the continuing education of all members of the workforce. The concerns were not specific to a particular sector of the field or discipline, but were described as generally applicable to the field as a whole.

The strategic planning process yielded seven objectives designed to promote the relevance, effectiveness, and accessibility of training and education. The first objective centers on the further development of core competencies and focused competencies for specific areas of practice. There is a glaring need to develop core competencies for mental health practice, similar to those developed in the substance use disorders sector of the field. Equally important is the need to link organizations that are working on competency development in different sectors of the field, so that they can inform each other's efforts and avoid duplication or, much worse, the development of narrow competency sets that miss essential elements of practice. The second objective focuses on the development of competency-based curricula. Further work on this objective is needed across the many areas of practice in behavioral health, and there is an immediate need for portable, model curricula to be developed for entry-level nondegree and bachelor's-degreed personnel working in mental health systems. As a third objective, it is incumbent on organizations that provide education and training to adopt teaching practices that have evidence of effectiveness, and for organizations that accredit training programs to require such adoption.

Expanded use of information technology can serve to increase access to training, and thus constitutes a fourth objective for this goal. The fifth goal is to ensure that every member of the behavioral health

workforce develops basic competencies in the assessment and treatment of persons with substance use disorders and co-occurring mental and addictive disorders. This will require a national initiative to identify and overcome the obstacles that have prevented major progress on this critical objective. An additional objective is to shape demand for relevant and effective training by educating prospective students about best practices in education to help them become more informed consumers as they select from among educational options. Finally, the field must identify and implement strategies to encourage and sustain the use of newly acquired skills in practice settings to counter the tendency for systems, organizations, and supervisors to thwart rather than support constructive changes in practice patterns.

Given the scarcity of resources, it is imperative to provide the next generation of prevention and treatment specialists with current knowledge and the practical skills needed to work in modern health care systems. To accomplish this, it is essential to first understand and then address the roadblocks that prevent the timely updating of curricula, training programs, accreditation standards, and certification and licensure processes. These are the key elements and drivers of education and training systems.

**GOAL 5: Actively foster leadership development among all segments of the workforce.**

The stark reality is that most leaders currently in the behavioral health field are part of the “graying” workforce, nearing retirement. Unfortunately, many of the federally funded training stipends and leadership programs that supported both the entry of these individuals into the field and their professional development no longer exist. Simultaneously, the pressure on leaders has increased exponentially, driven by demands for increased access, efficiency, and quality in the organizations that they manage. Leadership is essential and needs to be explicitly developed among all segments of the behavioral health workforce, including persons in recovery and families, educators, prevention specialists, treatment providers, policy makers, and the individuals who manage accreditation, certification, and licensure systems. In fact, developing and expanding a cadre of leaders among persons in recovery, youth, and family members is particularly critical in achieving transformation of current service systems and models of care. Leadership must be broadly defined to encompass not only organizational and change management, but also coalition and community building, team and program management, and the provision of supervision.

To achieve this strategic goal, the competencies necessary for leadership roles in behavioral health must be identified. Particular attention must be given to developing core leadership competencies that can be adapted to the different sectors of this field. The development of competency sets for supervisors is also a high priority. Available curricula for leadership development must be identified and further developed to ensure that the core competencies are adequately addressed. Increased support should be allocated to

the formal, continuous development of emerging leaders in the field. This will involve expanded training initiatives, release time to participate in training, mentorship opportunities, and recognition and rewards tied to advancement. Leadership development initiatives should be formally evaluated and refined based on the resulting data regarding the impact of these efforts.

Directing scarce resources toward the development of leaders in all sectors of the field and at multiple levels of the workforce will increase the numbers and skills of individuals who are positioned to educate the workforce effectively and to mold the environment in which the workforce will function. Both organizational development and human resource development are essential tasks in the effort to achieve improvements in prevention and treatment. Because leaders are uniquely positioned to impact systems and the workforce within them, the Annapolis Coalition has concluded that leadership development, as a strategic goal, offers high potential to transform behavioral health care.

**GOAL 6: Enhance the infrastructure available to support and coordinate workforce development efforts.**

The issue of infrastructure to support and sustain the workforce emerged at every turn in the planning process. There are few structures through which to coordinate existing efforts to develop the workforce, and the structures that do exist tend to be specific to content, discipline, or practice setting. Few organized vehicles exist for assembling, analyzing, and disseminating knowledge on workforce practices or providing technical support. There are few sources of financial support to develop innovative workforce practices. The current financing infrastructure for behavioral health services actually undermines the workforce, in various ways, as it strives to provide safe and effective care. Other infrastructure problems involve the paucity of reliable and valid data to inform workforce practices, the generally weak capacity in the human resources departments and training units of behavioral health organizations, and the limited information technology available as an aid for training, a tool to assist the workforce in providing prevention and treatment services, or as a vehicle for tracking and managing workforce activity.

Eight objectives were identified to support the achievement of this strategic goal. First and foremost is the need to develop a technical assistance infrastructure that links existing sources of workforce expertise and expands capacity to provide information, guidance, and support to the field on effective workforce development practices. This should be complemented by a standing SAMHSA workforce team and a federal task force charged with prioritizing, coordinating, and implementing federal interagency efforts on workforce development. It is recommended that the federal government and private foundations establish workforce development funds to support demonstrations and dissemination of innovative workforce practices. The economic market for services must be altered so that it more effectively

supports improvement in care and strengthens the workforce, through mechanisms such as increased parity in coverage for behavioral health and greater use of provider payment incentives.

Additional infrastructure objectives focus on the increased use by all stakeholders of data to track, evaluate, and manage key workforce issues through their continuous quality improvement processes. The human resources and training infrastructures, which have been downsized in many organizations, must be strengthened in terms of their role, resources, and levels of expertise. Information technology should be increasingly employed, not only to train the workforce, but also to provide it with real-time decision support, to track and manage work flow, and to reduce the enormous burden of redundant and purposeless reporting of clinical and administrative data. Many of these objectives can be promoted by identifying and accrediting “Magnet Centers” in workforce best practices that can model and disseminate effective practices in recruitment, retention, training, and education.

With so many unmet needs among persons with mental illnesses and substance use disorders, there is a natural reluctance to invest in infrastructure. Policy makers and program managers tend to pour every available dollar into direct service. And yet, this is precisely the dynamic that has contributed to a workforce that is now inadequately prepared and supported. The cogent analysis of workforce financing provided by Horgan and colleagues as part of this planning process, which appears in the full report, describes how organizations have “stretched” or “diluted” inadequate resources to meet demand, leading to “...under-capitalization, substitution of lower-cost workers, ... downward pressure on workers’ incomes...” and difficulty providing evidence-based, quality care. Like most other resources, human resources require maintenance, development, and support in order to be effective and efficient. Infrastructure development is simply essential to sustain the human resources in this field.

**GOAL 7: Implement a national research and evaluation agenda on behavioral health workforce development.**

A recurrent finding during the planning process was the lack of reliable and valid data on the status of the workforce and on workforce development strategies. Despite the centrality of the workforce to the delivery of care, it is but occasionally the focus of scholarly articles and reviews (Hall & Hall, 2002; Mor Barak, Nissly, & Levin, 2001), and seldom the focus of research. While many behavioral health organizations are increasing efforts to address their workforce problems, it is uncommon for the outcome of these efforts to be evaluated with even a modicum of rigor. With few exceptions, the evidence on workforce practices and interventions remains largely anecdotal.

It is imperative to build a strong workforce research and evaluation base within behavioral health. Developing a substantive body of empirical knowledge on workforce development requires a national research agenda that systematically examines the effectiveness of practices related to recruitment,

retention, education, training, and the sustained adoption of newly learned skills in real-world service environments. The Annapolis Coalition recommends the development of a national research agenda that (1) supports empirical investigation principally focused on workforce topics, and (2) greatly expands the examination of workforce variables and practices in the portfolio of all other ongoing behavioral health prevention and treatment research. The recommended mechanism for building this national research agenda involves the creation of a federal Research Collaborative on Workforce Development comprising representatives from the numerous federal agencies that fund behavioral health research.

As a second objective, behavioral health organizations should use data-driven continuous quality improvement processes as the foundation for formal evaluation of their workforce development efforts. This necessitates that organizations develop, or perhaps acquire through consultation, greater technical expertise on evaluation methods.

The absence of a timely, robust, reliable, and valid body of data on which to base workforce development efforts cannot be addressed overnight. Federal research priorities must be shifted to include a more thorough examination of workforce variables in the context of prevention and treatment studies, and to fund workforce development research as an explicit area of study. Behavioral health organizations need to adopt data-driven approaches to assessing and addressing workforce needs, and routinely evaluate the impact of their interventions. Mechanisms must be created to summarize, synthesize, and disseminate the new knowledge that is generated so that it can inform subsequent workforce development efforts in the field.

## FOCUSED TOPICS & THE SEARCH FOR INNOVATION

The core set of strategic goals and objectives was derived from reviews by the expert panels and work groups of workforce issues affecting diverse populations and sectors of the field. The desired outcome was to provide strategic direction to the field by focusing on core, common, or cross-cutting goals, as described in the preceding sections. While detailed strategic plans for specific sectors or populations were not developed, the panels examined their respective areas in detail and generated a summary that is included in the section of the full report on “focused topics”. These topics focus on children and youth, and their families; consumers and families (adult mental health); cultural competency and disparities; older adults; rural health care, school-based mental health; substance abuse prevention; and substance use disorders treatment. In addition, there is a report on the critical issue of workforce financing.

Many of the recommendations in this plan are drawn from exemplary workforce practices identified by the expert panels and work groups. Pockets of innovation in recruitment, retention, education, and training

exist throughout the country and serve as models, demonstrating practical and affordable strategies for strengthening the workforce. Replicating a previous search for innovation (O'Connell, Morris, & Hoge, 2004), senior advisors and their expert panels and work groups were asked to identify up to three innovative practices for each focused topic using criteria adopted from the Kennedy School at Harvard University for its annual Innovations in Government award (Hassel & Steiner, 2000). Those criteria focus on the novelty, significance, transferability, and effectiveness of a practice. The identified innovations are referenced and briefly described in various sections of the Action Plan as Innovation Highlights. More detailed descriptions of the innovations are available through the Annapolis Coalition's Web site ([www.annapoliscoalition.org](http://www.annapoliscoalition.org)).

### NEXT STEPS: LEVERAGING CHANGE

This Action Plan provides a blueprint for strengthening the behavioral health workforce. Guided by senior experts in workforce development from diverse sectors of the field, the expert panels and work groups have reviewed the relevant literature, examined available evidence, sought the opinions of thousands of stakeholders, and scoured the country for innovative recruitment, retention, training, and other workforce development practices. The product is a priority set of seven strategic *goals*, each of which has been translated into specific *objectives* and highly specific *actions* that are needed to achieve the broad goals. Preliminary Implementation Tables, which appear as an appendix of the full report, carefully link the goals, objectives, and actions to recommended stakeholders so that the reader can identify possible action steps that may be most relevant to his or her organization or role.

There is a compelling need for stakeholders throughout the field to take concerted action to stem the growing workforce crisis – and concern that such action will not occur. The problems and issues identified in this report are not new, as they have been previously documented and, for decades, have been the nemesis of managers and administrators throughout prevention and treatment systems. In a recent report, the Institute of Medicine Committee on Improving the Quality of Health Care for Mental and Substance-Use Conditions concluded that workforce issues "...have been the subject of many short-lived, ad hoc initiatives that overall, have failed to provide the sustained leadership, attention, resources, and collaborations necessary to solve these multifaceted problems" (IOM, 2006, p. 286).

Translating recommendations into action requires significant attention to the *levers of change*; the seemingly small forces that can exert enormous influence on a much larger mass. This metaphor borrows directly from the concept of a lever in physics: Properly placed, balanced, and utilized, a lever creates a mechanical advantage that produces significant movement beyond that which could be expected if the same amount of force were applied in less strategic ways.

It is worth noting that the workforce, itself, is viewed as a lever of change for improving the quality of services provided in this country (IOM, 2001, 2004). More effective recruitment, retention, and training practices are considered levers of change for achieving transformation in our systems of care (New Freedom Commission on Mental Health, 2003).

Several levers of change that can have a positive impact on the workforce have been identified by the Institute of Medicine (IOM) in its report *Health Professions Education: A Bridge to Quality* (IOM, 2003) and the recent report on mental and substance use conditions (IOM, 2006). These levers include financing, licensing, credentialing, accreditation, and faculty development. Organized advocacy is another potential lever that warrants focused attention. In addition to the IOM reports, SAMHSA/CSAT's *Changing the Conversation: Improving Substance Use Treatment; The National Treatment Plan Initiative* (DHHS, 2000) and its more recent *Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce* (DHHS, 2005a) represent two additional clear and relevant guides to workforce development that identify levers of change in the substance use arena.

If the behavioral health field is to address the workforce crisis seriously, a number of key elements will be required: a clear vision; a practical blueprint; a structure for implementation; methods for monitoring progress; collaboration across the various sectors in the field; and careful attention to the levers of change. The fate of this agenda at the national level will be influenced by a complicated set of political and economic forces. No matter what that fate, the Action Plan has significant relevance for the individual reader, who is encouraged to pursue the following course of action:

- Develop a personal, professional development plan, designed to strengthen your own skills. Pursue it with fervor. Revisit it and update it often.
- Ensure that the organization in which you work has a written workforce development plan that addresses the seven strategic goals. Pursue it with fervor. Revisit it and update it often. Collect workforce data to evaluate progress.
- Learn from persons in recovery, youth, and their families. Seek them out as full partners in all efforts to strengthen your workforce.
- Reconnect with the community that surrounds you. Build its capacities. Offer it support. Accept support from it.
- Become a mentor. Encourage young people to join the workforce. Extol the virtues of caring for others and of changing lives.
- Convey hope about the future to all whom you encounter.

The collective efforts of many individuals, institutions, and organizations, all working to strengthen themselves and each other, will make a difference. There can be no excellent general health care without competent behavioral health care, and the workforce remains the most essential ingredient for success in the development of resilience and for ensuring positive outcomes for people in recovery and their families.

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## QUICK REFERENCE GUIDE TO STRATEGIC GOALS & OBJECTIVES

**GOAL 1: Significantly expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.**

Objective 1: Provide information and education to individuals in care or recovery and their families to enable them to fully participate in or direct their own care and to assist and support each other.

Objective 2: Develop shared decision-making skills among individuals receiving care and their families and service providers.

Objective 3: Significantly expand peer and family-support services and routinely offer them in systems of care.

Objective 4: Increase the employment of individuals in recovery and family members as paid staff in provider organizations.

Objective 5: Formally engage persons in recovery and family members in substantive roles as educators for other members of the workforce in every provider training and education program.

**GOAL 2: Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.**

Objective 1: Support communities in their development of the core competencies of assessment, capacity building, planning, implementation, and evaluation.

Objective 2: Increase the competency of the behavioral health workforce to build community capacity and collaborate with communities in strengthening the behavioral health system of care.

Objective 3: Strengthen existing connections between behavioral health organizations and their local communities.

**GOAL 3: Implement systematic recruitment and retention strategies at the federal, state, and local levels.**

Objective 1: Disseminate information and technical assistance in effective recruitment and retention strategies.

Objective 2: Select, implement, and evaluate recruitment and retention strategies tailored to the unique needs of each behavioral health organization.

Objective 3: Expand federal financial incentives, such as training stipends, tuition assistance, and loan forgiveness, to increase recruitment and retention.

Objective 4: Provide wages and benefits commensurate with education, experience, and levels of responsibility.

Objective 5: Implement a comprehensive public relations campaign to promote behavioral health as a career choice.

Objective 6: Develop career ladders.

Objective 7: Expand the use of “grow-your-own” recruitment and retention strategies focused on residents of rural areas, culturally diverse populations, and consumers and families.

Objective 8: Increase the cultural and linguistic competence of the behavioral health workforce.

**GOAL 4: Increase the relevance, effectiveness, and accessibility of training and education.**

Objective 1: Identify core competencies and focused competencies for behavioral health practice.

Objective 2: Develop and implement competency-based curricula.

Objective 3: Adopt evidence-based training methods that have been demonstrated as effective through research.

Objective 4: Use technology to increase access to and the effectiveness of training and education.

Objective 5: Launch a national initiative to ensure that every member of the behavioral health workforce develops basic competencies in the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders.

Objective 6: Educate prospective students about best practices in training and education to inform their selection of a training program or training provider.

Objective 7: Identify and implement strategies to support and sustain the use of newly acquired skills in practice settings.

**GOAL 5: Actively foster leadership development among all segments of the workforce.**

Objective 1: Identify leadership competencies tailored to the unique challenges of behavioral health care.

Objective 2: Identify effective leadership curricula and programs and develop new training resources to address existing gaps.

Objective 3: Increase support for formal continuous leadership development with current and emerging leaders in all segments of the workforce.

Objective 4: Formally evaluate leadership development programs based on defined criteria and revise the programs based on outcomes.

**GOAL 6: Enhance the infrastructure available to support and coordinate workforce development efforts.**

Objective 1: Create a National Technical Assistance Structure that coordinates and provides information, guidance, and support on workforce development to the behavioral health field and advises the federal government.

Objective 2: Create a federal Behavioral Health Workforce Partnership, led by a SAMHSA Workforce Team.

Objective 3: Finance workforce demonstrations through a National Workforce Development Fund and foundation-sponsored initiatives.

Objective 4: Change the economic market for services to create conditions that improve the quality of care and strengthen the workforce.

Objective 5: Increase the use of data to track, evaluate, and manage key workforce issues.

Objective 6: Strengthen the human resources and training functions, staffing, and levels of expertise in behavioral health organizations.

Objective 7: Promote the increased availability and use of information technology to support the workforce during training and service delivery.

Objective 8: Identify Magnet Centers in workforce best practices, drawing on the “Magnet Hospital” concept from the field of nursing.

**GOAL 7: Implement a national research and evaluation agenda on behavioral health workforce development.**

Objective 1: Increase the quantity and quality of workforce-related research through creation of a federal interagency research collaborative.

Objective 2: Increase the quantity and quality of formal evaluations of workforce development practices by providing technical assistance to the field.

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# Review of Recovery Literature

## A Synthesis of a Sample of Recovery Literature 2000

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Ron Manderscheid, Ph.D., Director of the CMHS Survey and Analysis Branch, developed the partnership to fund and support this project and several others that are known jointly as the Recovery Project. Previously, Dr. Manderscheid supported presentations on recovery at both the National Conference on Mental Health Statistics and the Southern Regional Conference on Mental Health as well as at other conferences and meetings.

The Recovery Project represents the melding of several strands of interest in recovery. The MHSIP Policy Group was concerned about how to measure the concept of recovery and sponsored a major effort to address this issue. On a parallel track, the NASMHPD President's Task Force on Performance Measures included the concept of "recovery/ hope/personhood" in its framework of performance indicators which are being developed and tested in the CMHS-funded, 16-state study.

Funding for the Recovery Project supported three tasks: (1) establishment of a Recovery Advisory Group of consumer leaders (funds provided by the CMHS Survey and Analysis Branch),(2) development of a compendium of instruments that measure recovery (funds provided by The Evaluation Center@HSRI) and (3) development of the *Review of Recovery Literature* (funds provided by NTAC/NASMHPD).

The Recovery Advisory Group was instrumental in accomplishing all of the products of this project, and members must be acknowledged for their thoughtful, caring, comprehensive and consistent participation in the monthly teleconferences as well as in the exchange of materials on recovery. Group members are as follows:

Jean Campbell, Ph.D.	Sylvia Caras, Ph.D.
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It was a pleasure and a delight to chair this group and to benefit from its members' diverse knowledge and experience.

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## PREFACE

Recovery has been a major interest expressed by consumer and other members of the Mental Health Statistics Improvement Program (MHSIP) Policy Group, which has made this topic one of its areas of emphasis. The *Review of Recovery Literature* is one of three projects that make up the Recovery Project. The other two are the establishment of a Recovery Advisory Group of consumer leaders and the development of a compendium of instruments that measure recovery. The Recovery Project is jointly supported by the MHSIP Policy Group, the Survey and Analysis Branch of the federal Center for Mental Health Services (CMHS), The Evaluation Center@HSRI and the National Technical Assistance Center for State Mental Health Planning (NTAC) of the National Association of State Mental Health Program Directors (NASMHPD).

The Recovery Advisory Group was composed of a number of consumer leaders from across the country who met by teleconference once a month, with financial support from the CMHS Survey and Analysis Branch. They discussed recovery from their own perspectives and the perspectives of the consumers with whom they worked. They exchanged, read and discussed a tremendous amount of material about recovery, both published and unpublished.

A major outcome of these teleconferences is The Recovery Advisory Group Recovery Model, which is discussed in the section on models in this publication. In addition the group recommended that the thoughts, experiences and materials discussed during these teleconferences be collated, coordinated and put into an organized format to inform the mental health community about the types of literature being produced on the concept of recovery. This was the beginning of the *Review of Recovery Literature*.

An in-depth view of consumer writings about recovery, research on recovery and measurement of recovery was developed as a background paper for the 1999 *Mental Health: A Report of the Surgeon General*. This and other background papers written by consumers are scheduled to be published in an upcoming issue of *Psychiatric Rehabilitation Skills*.

The Recovery Advisory Group also initiated an intensive search for instruments to measure recovery and recovery-related areas and to discover information about consumer involvement in the development of these instruments and documentation about the testing of the instruments with appropriate populations. This effort resulted in the document *Can We Measure Recovery? A Compendium of Recovery and Recovery-Related Instruments* published by The Evaluation Center@HSRI. This has become the basis for a major initiative to develop and test a measure of recovery and the recovery environment through the 16-state study funded by the Center for Mental Health Services.

A wealth of other information and literature is available about recovery that did not arise from research or measurement, but that is valuable and informative nonetheless. Thus using the resources described above and adding the wider collection of information and material developed on recovery became the focus of the *Review of Recovery Literature*.

A major development has been the interest policy makers have expressed in the concept of recovery and the various ways this is implemented. Can this interest—and the collaboration of consumers, providers and policy makers—result in a paradigm shift in the mental health system that actually encourages and supports recovery? Let us hope so.

*Ruth O. Ralph, Ph.D.*

## INTRODUCTION

There is a great deal of interest in recovery throughout the mental health community. Consumers of mental health services who discover that there is such a concept are given hope that they can reach some level of normal life. Providers are realizing that to have their clients recover is to their advantage, not only so that the people they serve can enjoy better health, but also so that they can have enough staff and time to assist those who are coming into the system. Payers for mental health services (e.g., health maintenance organizations [HMOs], Medicaid) are most interested in being able to reduce services and costs. Funders of services (e.g., state mental health agencies, federal programs, legislators) want to see their dollars produce success. Thus, recovery has become the latest “buzz word” in mental health circles. What it is, how it is defined and how it is accomplished is the subject of many discussions, writings and presentations.

The purpose of this paper is to review the different types of literature on recovery in mental health, both published and unpublished, and to provide examples of each type.

We will start with a brief review of the origins of the concept of recovery in mental health and continue with some definitions of recovery. Types or categories of recovery literature will be described, with illustrations of each category. Finally, we will attempt to summarize what we have learned and draw conclusions from the content of the literature, including making recommendations for further study.

It should be noted that the recovery literature discussed in this paper is only a small part of the total body of literature about recovery and thus provides examples of what can be found in this expanding field. Although efforts have been made to identify, collect and review recent publications, presentations and unpublished papers, this review should be thought of as a “point-in-time” summary because the recovery literature is growing daily at an enormous pace.

### EMERGENCE OF THE CONCEPT OF RECOVERY

It should be noted that recovery is a foreign concept to many in the mental health field. Until recently, recovery was not thought possible by many family members, providers, researchers and funders of services. In fact, the possibility of recovery is still debated by some.

“The concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings” (Deegan, 1996). The simple fact that this statement was made in a recent publication indicates the extent of the belief that people with mental illness do not recover, will always remain a burden on society and must be “taken care of” rather than encouraged to become independent, contributing members of society. It also indicates the extent of the need for the systematic and extensive study of how people become well and how they stay well in spite of, and perhaps because of, the barriers they face.

In the early 1980’s, the term recovery seldom appeared in articles or concept papers. For example, Houghton’s (1982) personal account was titled “Maintaining Mental Health in a Turbulent World,” and Leete’s (1989) was

called “How I Perceive and Manage My Illness.” The Well-Being Project (Campbell & Schraiber, 1989) never mentions recovery, although it is a study of how consumers view their struggle and how they define well-being. The phrase “from patient-hood to person-hood” was a theme in this study. Some non-consumers became convinced that recovery is possible, or at least were ready to listen, as they read and heard consumers’ personal stories about their struggle with and overcoming of the difficulties they faced. Others adopted the term to describe the success of the intervention or interventions they felt “worked” for people with mental illness. In the late 1980’s and early 1990’s, the word recovery was introduced in consumer writing by Deegan (1988) in “Recovery: The Lived Experience of Rehabilitation” and in non-consumer commentary by Anthony (1993) in “Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990’s.”

### RECOVERY DEFINED

The word recovery means “to get back: regain” or “to restore (oneself) to a normal state” (*Webster’s II New Riverside University Dictionary*, 1984). It has been used extensively in the field of substance abuse where the concept of “recovery” means people go back to pre-drinking or pre-drugging lives.

Recovery in mental health is defined in the writings of consumers. The following quotations were included in a paper on recovery (Ralph, 2000) prepared as background information for *Mental Health: A Report of the Surgeon General (1999)*. These selected comments illustrate both the diversity and the commonalities of consumers’ perspectives on recovery.

- ▣ “Recovery is an ongoing process of growth, discovery, and change” (Stocks, 1995).
- ▣ “Recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again. The need is to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution” (Deegan, 1988, p. 15).
- ▣ “One of the elements that makes recovery possible is the regaining of one’s belief in oneself” (Chamberlin, 1997, p. 9).
- ▣ “Having some hope is crucial to recovery; none of us would strive if we believed it a futile effort. I believe that if we confront our illnesses with courage and struggle with our symptoms persistently, we can overcome our handicaps to live independently, learn skills, and contribute to society, the society that has traditionally abandoned us” (Leete, 1988, p. 52).
- ▣ “A recovery paradigm is each person’s unique experience of their road to recovery .... My recovery paradigm included my reconnection which included the following four key ingredients: connection, safety, hope, and acknowledgment of my spiritual self” (Long, 1994, p. 4).

- ▣ “What there is now that is new is the beginning of trust that the bad times will pass and the underlying strength will prevail. What there is now is insight about how externals affect me and how to better manage myself in connection with outside factors. What there is now is acceptance. I reinforce what I learn with an annual life review” (Caras, 1999, p. 2).
- ▣ “To return renewed with an enriched perspective of the human condition is the major benefit of recovery. To return at peace, with yourself, your experience, your world, and your God, is the major joy of recovery” (Granger, 1994, p. 10).

Some consumer descriptions of recovery include activities or actions that move the person toward wellness and enable or enhance recovery.

- ▣ “Creativity in my life has been my salvation” (McDermott, 1990, p. 13).
- ▣ “Advocacy for others has had a positive effect on my mental health” (Weingarten, 1994, p. 370).

Anger and its energizing effect are also included in these personal definitions of recovery. Unzicker (1989) describes her reaction while reading Judi Chamberlin’s book, *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (1978). “It was Judi’s story of suffering and survival that jump started my rage. Judi’s book awakened in me a spirit of defiance, will and courage that I am still uncovering, like opening a perpetual birthday present” (Unzicker, 1989, p.72). In addition to constructive anger, recovery also includes advocacy for self and others, acceptance of personal responsibility and asking for and accepting help (Ralph, 1997).

Other descriptions include:

- ▣ Recovery is a continuing, deeply personal, individual effort that leads to growth, discovery and the change of attitudes, values, goals and perhaps roles (Anthony, 1993).
- ▣ It involves hope, courage, adaptation, coping, self esteem, confidence, a sense of control or free will (Blanch et al., 1993).
- ▣ It includes physical and mental health, and economic and interpersonal well-being (DeMasi et al., 1996).
- ▣ Recovery includes personal empowerment and a spirituality/philosophy, which gives meaning to life. It is accomplished one step at a time. It is deeply personal, and can be done only by the individual who is recovering (Beale & Lambric, 1995).

## RECOVERY DOES NOT DESCRIBE WHAT HAPPENS

Many consumers/survivors of mental health services feel that the word recovery does not truly or fully describe the journey through mental illness or the results of the journey. One survivor of childhood sexual abuse commented that recovery implies that you return to something you were before the illness. “But I have no before!” she cried. Many consumers whose lives have been interrupted by bouts of mental illness feel that they have gone beyond where they were when the illness struck. Many have started or continued their education, reached new heights in their careers or begun new careers.

Caras writes: “I am not recovered. There is no repeating, regaining, restoring, recapturing, recuperating, retrieving. There was not a convalescence. I am not complete. What I am is changing and growing and integrating and learning to be myself. What there is, is motion, less pain, and a higher portion of time well-lived” (Caras, 1999, p. 1).

There is continued discussion about what would be a better word than recovery. “Healing is seen as broader than recovery. Healing often emphasizes the healing from an injury or trauma or hurt in life. Healing is more suggestive of the mind/body split. Healing implies that the self has a role in the process. Recovery connects more with the 12 step programs” (Jeanne Dumont, quoted in Fisher and Deegan, 1998, p. 6).

Cohan and Caras (1998) introduced the word transformation as a substitute for the word recovery:

*Our lives seem not to follow a traditional linear path; our lives appear to be like advancing spirals. We relapse and recuperate, we decide and rebuild, we awaken to life and recover/discover, and then we spiral again. This spiral journey is one of renewal and integration, the dynamic nature of this process leads to what can only be described as transformation. Recovery and rehabilitation imply that something was once broken and then was fixed. Transformation implies that proverbial making of lemonade after life hands you lemons. It is the lesson, hard learned, of the opportunity available in the midst of crisis that evokes a substantive change within ourselves (p. 1).*

After describing her spiritual journey through and past mental illness, Clay (1994) provides this summary: “I really do not want to be called recovered. From the experience of madness I received a wound that changed my life. It enabled me to help others and to know myself. I am proud that I have struggled with God and with the mental health system. I have not recovered. I have overcome” (p. 10).

## TYPES OF RECOVERY ACTIVITIES

Several types of activities are connected with, describe, interpret or may have an impact on recovery. The following examples are not intended to be the total of what is available. The types of literature associated with these activities will be discussed in the next section.

First, there is the continuation of the writing and collecting of personal accounts—stories written or told that describe the struggle with and overcoming of mental illness and accompanying social challenges. These may be included in presentations at conferences and workshops, exchanged on the internet, printed in consumer newsletters or included in peer-reviewed journals. For example, the periodicals *Psychiatric Services*, *Psychiatric Rehabilitation Journal* and *Psychiatric Rehabilitation Skills* regularly publish personal accounts.

Second, there are activities that offer consumers and mental health providers information about how to recover. Consumer conferences in a number of states have either focused on recovery as their primary theme, or have included sessions on recovery. Some of these conferences have been funded or sponsored by state mental health agencies. The annual national Alternatives Consumer Conference includes many sessions about recovery, wellness and making your own and others' lives better. Consumer newsletters also provide this type of information. Workshops and training in how to recover have been developed and are conducted by consumers and non-consumers. Presentations on recovery definitions and methods are made at local and national conferences. Papers are written and distributed. Personal accounts often include information about how to recover and how to continue to be well.

Third, both consumers and non-consumers conduct research focusing on recovery. These include a wide variety of methods and focuses, including consumer surveys, qualitative studies, outcome studies, development and testing of specific interventions, both quantitative and qualitative instrument development, and model development and testing.

Fourth, there are policy development activities. Many state mental health agencies are seeking ways to implement policies and procedures to promote recovery. Federal agencies are funding the development of “indicators” of success in various areas of the mental health system. Recovery is one of these areas, and indicators are being sought to ensure that recovery has taken place and that mental health systems are providing an environment in which recovery can occur.

## TYPES OF RECOVERY LITERATURE

**L**iterature about recovery includes:

- ▣ personal accounts that continue the telling of personal stories by consumers to illustrate the many and varied ways recovery takes place;
- ▣ educational materials to teach concepts and methods of recovery and self-care;
- ▣ development of models to show how and when recovery happens; research;
- ▣ development and testing of measurement tools;
- ▣ policy development; and
- ▣ general discussion and opinion.

### PERSONAL ACCOUNTS

Consumers continue to tell personal stories of their struggle with mental illness, the methods they learned to cope with their illness, the barriers they faced and their journeys to wellness. This is one of the ways that mental health consumers have used to communicate to other consumers and non-consumers that recovery can and does take place. These often include definitions of recovery and descriptions of processes, supports and activities that have enabled or enhanced their recovery.

Ridgeway (1999, unpublished manuscript) analyzed four early consumer recovery narratives (Lovejoy, 1982; Deegan, 1988; Leete, 1989; Unzicker, 1989) with a constant comparative method to find common themes. These themes are as follows:

- ▣ Recovery is the reawakening of hope after despair.
- ▣ Recovery is breaking through denial and achieving understanding and acceptance.
- ▣ Recovery is moving from withdrawal to engagement and active participation in life.
- ▣ Recovery is active coping rather than passive adjustment.
- ▣ Recovery means no longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self.
- ▣ Recovery is a journey from alienation to purpose.
- ▣ Recovery is a complex journey.
- ▣ Recovery is not accomplished alone—it involves support and partnership.

In a review of recovery literature, Ralph (2000) identified the following four dimensions of recovery found in personal accounts:

**Internal factors:** factors that are within the consumer, such as awareness of the toll the illness has taken, recognition of the need to change, insight about how change can begin and determination to recover;

**Self-managed care:** an extension of the internal factors in which consumers describe how they manage their own mental health and how they cope with the difficulties and barriers they face;

**External factors:** include interconnectedness with others; the supports provided by family, friends and professionals; and having people who believe that they can cope with and recover from their mental illness; and

**Empowerment:** “a combination of internal and external factors—where the internal strength is combined with interconnectedness to provide the self-help, advocacy, and caring about what happens to ourselves and to others” (Ralph, 2000).

## HOW TO RECOVER

Information about how to recover and maintain mental health is often found in personal accounts. The author describes the things he/she learned to put in place in order to regain and maintain mental health. This is called self-managed care by Fisher (1996) and Ralph (2000).

Houghton (1982) provides an excellent example of self-managed care, which can be appreciated only in part by the following quotes:

- “My illness taught me (the hard way) the importance of meaningful work, good patterns of rest and sleep, exercise, diet, and self-discipline. Once freed from the regulating shackles of medications, I had to substitute a reasonable routine, a slower pace, and a calm atmosphere.”
- “I began my new life by setting up a schedule for myself, by providing a structure for everyday living.”
- “Exercise and physical activity not only strengthen the body but serve as an emotional safety valve. Mental illness is often negative energy turned inward, exercise provides a healthy release from this energy.”
- “I view writing as a healthy form of transference. It purges my mind of information that interferes with action and helps to organize my thoughts into patterns of action.”
- “Another essential change in my life has been learning to set reasonable goals and to reach them. (I still struggle with what’s ‘reasonable.’) I learned that any change—such as a business trip or vacation—which drastically altered my routine, was stressful. Deadlines, other- or self-imposed, were harmful, especially if they were unrealistic (pp. 549-550).”

In addition to the examples and advice provided in personal accounts, information about recovery can be found in manuals, workbooks and training materials. Some of these materials describe their methods as models. Copeland (1994, 1997, 1999) has produced a number of books and manuals, and she also conducts

training activities and workshops. Spaniol and Kohler (1994b) have developed a workbook and training for recovery group leaders as well as a collection of personal accounts (1994a). Knight and colleagues conduct “Recovery Dialogues” and provide participants with materials (unpublished) to help them remember the points learned (personal communication). Numerous articles and presentations have been prepared by Fisher (e.g., 1996, n.d.), many of which have been published in the National Empowerment Center Newsletter.

Being in control is the way Deegan (1993) manages her life:

*To me recovery means I try to stay in the driver’s seat of my life. I don’t let my illness run me. Over the years I have worked hard to become an expert in my own self-care. Being in recovery means I don’t just take medications, rather I use medications as part of my recovery process. Over the years I have learned different ways of helping myself. Sometimes I use medications, therapy, self-help and mutual support groups, friends, my relationship with God, work, exercise, spending time in nature—all these measures help me remain whole and healthy, even though I have a disability (p. 10).*

## TYPES OF RECOVERY RESEARCH

**R**esearch on recovery from mental illness is relatively new and results vary, in part, due to the way the concept is operationalized. Some progress has been made in the theoretical description of recovery through the development of models.

### MODELS

When a search of the literature is made for models of recovery from mental illness, both treatment models and theoretical models are described. The choice has been made here to address only theoretical models, which in some way attempt to visualize the processes or the outcomes of recovery. Three theoretical models were found which have been developed to describe recovery. Only one of these has been tested empirically (DeMasi, et al., 1996). However, the other two models provide the basis for discussion and further description.

DeMasi and colleagues (1996) developed a model based on their review of the literature that explains recovery in terms of three areas of well-being: health (both physical and mental health), psychological (self-esteem, hope, coping and confidence) and social (economic and interpersonal quality of life). A number of scales were used to develop the Self-Help Survey which was mailed to individuals in New York state who used either traditional services only, self-help services only or a combination of traditional and self-help. The scales used were: the Colorado Symptom Index (Coen, Wilson, Shern & Bartsch, 1989) to measure symptoms of mental illness; Rosenberg's (1965) Self-Esteem Scale; the Mental Health Confidence Scale (Carpinello, et al., 2000); the Ways of Coping Scale (Folkman & Lazarus, 1988); the Hope Scale (Snyder et al., 1991) and several items to measure economic and interpersonal quality of life. The survey was mailed to a statewide sample of 956 individuals, with a total of 612 people returning a completed survey, a 64 percent return rate. Using confirmatory factor analysis, the structure of the hypothesized model was tested and supported. The results indicate that recovery spans beyond the mental health system into all human services, is supported by a combination of support services (e.g., health, housing, fiscal resources) and emphasizes the importance of a partnership between clinician and client and between traditional and alternative services.

Several versions of a recovery model have been published by Dan Fisher of the National Empowerment Center.<sup>1</sup> This model was first called the Empowerment Vision of Recovery from Mental Illness, (Fisher, 1994) and later the Empowerment Model of Recovery from Mental Illness (Fisher & Ahern, 1999). The narrative that accompanies the diagram that illustrates this model includes the following concepts:

- ▣ People are labeled with mental illness through a combination of severe emotional distress and insufficient social supports/resources/coping skills to maintain the major social role expected of them during that phase in their life.
- ▣ The degree of interruption in a person's social role is more important in affixing the label mental illness to someone than his or her diagnosis.

<sup>1</sup> The National Empowerment Center is a consumer-operated technical assistance center funded by the federal Center for Mental Health Services.

- Recovery is possible through a combination of supports needed to (re)establish a major social role and the self-management skills needed to take control of the major decisions affecting one's life.
- This combination of social supports and self-management helps the person regain membership in society and regain the sense of being a whole person (Fisher & Ahern, 1999, p. 13).

The Recovery Advisory Group Recovery Model (Ralph et al., 1999) was developed as a result of a series of monthly teleconferences with a group of consumer leaders who discussed recovery from their own experience, the experiences of those with whom they worked and their review of a considerable amount of literature on recovery. This model describes and defines recovery through a number of stages: anguish, awareness, insight, action plan, determination to be well and well-being/recovery. The path is not linear, and people do not simply move through one stage to the next, but may move back and forth among the various stages.

Consumers who developed this model indicate that recovery is both internal and external. The internal is what happens within oneself, while the external includes interactions with others. The following dimensions were chosen to describe the internal aspects of recovery: cognitive, emotional, spiritual and physical. The external dimensions consist of a person's actions and reactions to external influences, and interactions with people and situations as one moves across and through the stages of recovery. The following dimensions were used to describe the external aspect of recovery: activity, self-care, social relationships and social supports. Insight into oneself, "self talk" and growth must take place, but there also needs to be interaction with the world in which one lives. External influences (e.g., family, friends, community, mental health system) are also important for recovery, and they can support or deter recovery.

### DEFINITIONAL STUDIES

A consumer-run business in Ohio was asked by a county mental health board to develop and implement an evaluation strategy to identify strengths and weaknesses in the county mental health system. All of the consumers/survivors involved agreed that recovery was important, and they generated a list of abilities, behaviors and activities that were important to their recovery. These indicators, used in a pilot study in Ohio with 71 service recipients and in another study in Maine with 180 consumers who had been admitted to the state psychiatric institution at least once in the last seven years, were rated from most important to least important similarly by both groups (Ralph, Lambric & Steele, 1996; Ralph & Lambert, 1996). Both Ohio and Maine participants selected the same top four indicators.

1. The ability to have hope
2. Trusting my own thoughts
3. Enjoying the environment
4. Feeling alert and alive
5. Increased self-esteem
6. Knowing I have a tomorrow
7. Working with and relating to others
8. Increased spirituality

9. Having a job
10. Having the ability to work

The consumer group in Ohio also developed a set of statements to rate the impact of mental health professionals on their recovery. Clients in the Ohio county mental health system rated these statements from greatest to least impact:

1. Encourage my independent thinking
2. Treat me in a way that helps my recovery process
3. Treat me as an equal in planning my services
4. Give me freedom to make my own mistakes
5. Treat me like they believe I can shape my own future
6. Listen to me and believe what I say
7. Look at and recognize my abilities
8. Work with me to find the resources or services I need
9. Are available to talk to me when I need to talk to someone
10. Taught me about the medications I am taking

An examination of these statements identifies key issues which also arise in other accounts of recovery, such as encouragement, belief in abilities, empowerment (treating as equal), listening and believing, and free choice.

The Well-Being Project (Campbell & Schraiber, 1989) is a landmark effort in which mental health consumers conducted a multifaceted study in California to define and explore factors promoting or deterring the well-being of persons who were diagnosed with mental illness. The project developed research protocols that engaged consumers and survivors in development of research questions, instruments and methods. Four basic research strategies were utilized:

- ▣ review of relevant psychiatric literature,
- ▣ quantitative survey research,
- ▣ focus groups, and
- ▣ oral histories.

Respondents were interviewed in psychiatric hospitals, skilled nursing facilities, residential treatment centers, drop-in centers, mutual support groups and on the streets. Of the 331 clients who responded, 87 percent had been hospitalized; of the 53 family member respondents, 91 percent reported that their relative had been hospitalized. Nearly 60 percent of the clients surveyed indicated they could always or most of the time recognize signs or symptoms that they are having psychological problems (i.e., insight), and almost half reported that they can always or most of the time take care of the problem before it becomes serious. The most favored coping and help-seeking practices were to: write down their thoughts or talk the problem out (50 percent); eat (52 percent); call or see friends (52 percent); relax, meditate, take walks or a hot bath (54

percent); and call or go see a mental health professional (62 percent). Campbell (1993) defines the essential elements of well-being as follows:

*In response to questions that elicited what factors are essential to well-being, clients reported that it comes from good health, good food, and a decent place to live, all supported by an adequate income that is earned through meaningful work. We need adequate resources and a satisfying social life to meet our desires for comfort and intimacy. Well-being is enriched by creativity, a satisfying spiritual and sexual life and a sense of happiness (p. 28).*

## OUTCOME STUDIES

The classic outcome study on recovery from mental illness and the influence that mental health services, rehabilitation services in particular, have on recovery is the 32-year longitudinal study of patients from the Vermont State Psychiatric Hospital reported by Harding and colleagues (1987). George Brooks, superintendent of the hospital, selected a cohort of 269 chronic patients who had “sifted out of all the hospital admissions to the back wards” (Harding, Zubin & Strauss, 1988, p. 478). At the time of their selection for the study in the mid-1950s, these patients had been ill for an average of 16 years, totally disabled for 10 years and hospitalized continuously for 6 years. They participated in a pioneering rehabilitation program and were released in a planned deinstitutionalization process with community supports in place. These clients were followed up 32 years later (262 were traced, 97 percent of the original 269 patients). Thirty-four percent of the living people with a diagnosis of DSM-III schizophrenia experienced full recovery in both psychiatric status and social functioning, and an additional 34 percent of the people who attended the rehabilitation program were significantly improved in both areas. The definition of recovery used in this study is as follows:

*The universal criteria for recovery is defined as no current signs and symptoms of any mental illness, no current medications, working, relating well to family and friends, integrated into the community, and behaving in such a way as to not being able to detect having ever been hospitalized for any kind of psychiatric problem (Harding & Zahniser, 1994).*

A follow-back study matched a selection of patients hospitalized in Maine to the Vermont patients by age, sex and diagnosis, and compared outcomes between the two groups (DeSisto et al., 1995). It was found generally that Vermont subjects were more productive, had fewer symptoms and displayed better overall functioning and community adjustment. “It can be argued that the differences in outcome are likely to be attributable to the Vermont (rehabilitation) program, since it provided an opportunity for community adaptation in the context of an array of residential, work, and social opportunities which were all managed to ensure continuity” (DeSisto et al., 1995, p. 337).

In an overview of World Health Organization (WHO) studies on schizophrenia, de Girolamo (1996) found that “independent from the setting and contrary to the beliefs held in the psychiatric field for decades, there is a remarkable percentage of patients who recover from the illness” (p. 224). In 27 major long-term follow-up studies (including Harding’s) published between 1960 and 1991, the percentage of patients assessed as clinically recovered ranged from a low of 6 percent to a high of 66 percent, with an average of 28 percent and a

median of 26 percent. The percentage of patients who showed a social recovery ranges from a low of 17 percent to a high of 75 percent, with an average of 52 percent and a median value of 54 percent. “Some authors have proposed a challenging view of the very concept of chronicity, stating that a variety of environmental and psychosocial factors can affect patient outcome and induce a misperception of chronicity” (Harding et al., 1987).

In considering how traditional services (hospitalization, therapists) and the “empowerment oriented” approach of participation in self-help groups affect self-concept and social and economic outcomes, Markowitz and colleagues (1996) used data from the Self-Help Survey (DeMasi et al., 1996) to examine how these outcomes are affected by the different types of assistance (i.e., traditional or self-help). Involvement in self-help was found to have positive effects on self-concept and interpersonal quality of life. The strongest negative effects on self-concept and quality-of-life outcomes were found to be exacerbating symptoms. Traditional services were found to have a negative relationship with self-concept as well as with quality of life (Markowitz, et al., 1996).

The role of social relationships in recovery was studied by Brier and Strauss (1984) with 20 patients who had been hospitalized for a psychotic decompensation. Initial interviews in the hospital focused on obtaining a history of each person’s psychiatric problems and identifying any apparent relationships between these problems and work, friendships and family status. Data on social relationships during the one-year follow-up period were obtained from semi-structured monthly interviews. All of the patients described specific ways in which social relationships were beneficial. From these interviews, 12 categories were identified:

**Ventilation:** conversing with others;

**Reality testing:** assisting to maintain clear distinctions between reality and psychotic distortions;  
material support: helping with financial, housing and transportation problems;

**Social approval and integration:** receiving reassurance when people accept them and provide a sense of belonging;

**Constancy:** associating with people they knew before hospitalization, connecting current identity with pre-hospital identity and giving roots to existence;

**Motivation:** receiving encouragement to achieve higher levels of occupational and social functioning;

**Modeling:** observing the behavior of others and incorporating it into their own behavior;

**Symptom monitoring:** having others alert them to manifestation of symptoms;

**Problem solving:** discussing problems and getting concrete feedback;

**Empathic understanding:** being understood by people important to them;

**Reciprocal relating:** becoming an equal partner, able to share and be of assistance to others; and

**Insight:** acquiring more complete and accurate understanding of themselves.

The authors also identified two phases through which patients go toward their recovery from a psychotic episode: (1) convalescence—getting over the experience of the psychotic episode—and (2) rebuilding—putting one’s life back together, making plans for a new life and beginning an identity shift to being an “ex-mental-patient.”

The Consumer Leadership Education Program (LEP) is a 16-week psychoeducational program that prepares mental health consumers for leadership positions on community agency boards and committees. The LEP was designed in a participatory process with a consumer advisory group of 10 mental health consumers, research and program personnel who provided information about topics helpful to promote recovery. The curriculum design also utilized information from consumer interviews and focus groups addressing the recovery process. The training curriculum includes three segments: (1) attitude and self-esteem; (2) group dynamics and group process; and (3) board/committee functions and policy development.

In the evaluation of the LEP, Bullock and colleagues (2000) used wait-list groups as control groups and conducted pre-, post- and six-month follow-up assessments. In addition, qualitative as well as quantitative data were gathered to assist in understanding the change processes as well as the outcomes of the LEP. In comparison with control groups, trainees showed significant improvement on measures of consumer-rated symptoms, self-efficacy, empowerment and community living skills. Training participants reported significant improvement in their (1) ability to control negative and social symptoms of their psychiatric illness, (2) social relationships, (3) personal care and vocational skills and (4) personal power. There was also a trend toward improvement in overall attitude about recovery from mental illness, using the Recovery Attitude Questionnaire (Borkin et al., 1998).

The recovery process of incest survivors was studied by Godbey and Hutchinson (1996). A sample of 10 adult women who were incest survivors was recruited through word-of-mouth snowball sampling. Women were excluded if they had experienced suicidal ideation within the last 6 months or had been hospitalized for emotional difficulties in the last year. Formal, semi-structured, in-depth interviews focused on the healing process. Additional data from the autobiographical accounts of other incest survivors were coded along with the interviews. Using grounded theory method, data were coded line by line. The authors explain their theory of burying the integral self:

*Shengold (1989) called parental sexual and physical abuse soul murder, because children must literally bury, conceal, and lay away part of the self physically to survive. The work of recovery is to recognize that part of the self, the integral self, has been buried because of the pain of the abuse, and to resurrect the buried self (p. 306).*

Participants in this study described the resurrecting of the buried self as a complex, long and arduous process, but one that results in long-term satisfaction. They indicated that in order to accomplish this, they needed to

work with a trusted therapist, have emotional support from family and friends and, most importantly, have a real commitment to healing. Through careful analysis of the interview narratives, the authors identified a series of phases through which survivors must pass in their efforts toward recovery. These are (1) reappearing, (2) revivifying, (3) resuscitating, (4) renovating, (5) regenerating, (6) reanimating and (7) reincarnating. Each of these phases is discussed and illustrated based on information provided by the interviewees. The researchers conclude that reincarnating is accepting the experience of incest and all the associated life-experiences and weaving these experiences into an integrated life. The following words of a participant illustrates this point:

*To me at this point in my life (I'm 47) it means I'm one hell of a warrior. It means I am one incredible, powerful, magnificent being. I wouldn't relive a day of it. Yet I honor it at the soul level...and I honor what I've done with that. I honor every tear, every grief, every feeling...it has made me a tremendous therapist, a tremendous minister. It has led me on my path even when I was amnesic. It's leading me on my path, and I walk a magnificent path (p. 309).*

### MEASUREMENT OF RECOVERY AND HEALING

A compendium of recovery and related measures (Ralph, Kidder & Phillips, 2000) includes published and unpublished measures of recovery and other areas related to recovery. There are relatively few instruments that attempt to measure recovery compared with the number of instruments that measure other areas in mental health, for example, symptoms or satisfaction. Instruments in this compendium may measure something *about* recovery rather than recovery itself, or they may have been used in qualitative studies to define or identify perceptions about recovery. Thus three of the instruments in this compendium measure attitudes or personal vision, two are qualitative question sets and three provide Likert-type rating scales that may result in the measurement of recovery. All of these instruments ask for responses from the consumer. Because most of these instruments are works in progress, they provide little information about change over time or use of the instrument with an intervention. Further work needs to be done to assess the effectiveness of these instruments in measuring the impact of specific interventions to measure the course of recovery through the assistance of the mental health system. Cultural and geographic effects on recovery need to be examined, and measurements must reflect these concerns.

The following instruments, scales or qualitative question sets have been developed to study or measure recovery or healing. More detailed information about each one can be found in the compendium of recovery and related measures (Ralph, Kidder & Phillips, 2000).

*The Crisis Hostel Healing Scale* (Dumont, 2000) was developed through concept mapping with consumers and providers who were operating and using the Crisis Hostel in the federally funded Crisis Hostel Project.

*Recovery Assessment Scale* (Corrigan et al., 1999) was developed by analyzing four consumer stories of recovery, and items were developed from the identified concepts.

*Rochester Recovery Inquiry* (Hopper, Auslander & Blanch, 1996) is an open-ended, qualitative questionnaire.

*Recovery Attitudes Questionnaire (RAQ)* (Borkin et al., 1998; Steffan et al., 1999) was developed by a team comprising mental health consumers, professionals and researchers of the Hamilton County (Ohio) Recovery Initiative.

*Personal Vision of Recovery Questionnaire (PVRQ)* (Ensfield, 1998) “was designed to measure consumers’ beliefs about their own recovery.”

*The Recovery Interview* (ILGARD Research Team, 1998) is a qualitative questionnaire developed by the research team at the Ohio University Institute for Local Government Administration and Rural Development.

*Agreement with Recovery Attitudes Scale* (Murnen & Smolak, 1996) was developed by Knox County (Ohio) researchers in collaboration with consumers to assess change in attitudes with regard to movement toward a recovery process.

*The Recovery Scale* (Young & Ensing, 1998) was designed to be a comprehensive recovery measure, based on Young’s work with consumers.

#### MEASURES RELATED TO RECOVERY

The following instruments are examples of scales that measure concepts thought to be related to recovery. The involvement of consumers in the development of these scales was one criterion for selection.

The *Leadership Education and Training Assessment* (Bullock et al., 2000) included a number of scales (e.g., Making Decisions Empowerment Scale, Community Living Skills Scale, Recovery Attitudes Questionnaire) to measure the effectiveness of the Leadership Education and Training program in Ohio in which consumers were trained to take leadership roles on boards and committees.

*The Well-Being Scale* (Campbell & Schraiber, 1989) was developed by consumers and used with more than 350 consumers in a wide variety of settings (including psychiatric hospitals) in California.

*The Mental Health Confidence Scale* (Carpinello et al., 2000) was constructed and used as part of the data collection strategy in a study focused on factors that predict participation and nonparticipation in self-help groups.

The *Hearth Hope Scale* (Hearth, 1992) and the *Hope Scale* (Snyder et al., 1991) were developed by non-consumer researchers but were selected to use in studies of recovery because of the importance of hope.

*The Staff Relationships Scale* (Hornik, Ralph & Salmons, 1999) was developed because project leadership from the Albany and Boston sites of the Supported Housing Initiative Cross-Site Study felt that this topic was an important area of influence for recovery in people who were moving into supported housing.

*Making Decisions Empowerment Scale* (Rogers, Chamberlin, Ellison & Crean, 1997; Wowra & McCarter, 1999) was developed by a group of consumers with consultant researchers for the purpose of studying the empowerment of making decisions on self-help. After extensive development and pilot testing, a 28-item scale was tested with 271 members of 6 self-help programs in 6 states.

*The Consumer Empowerment Scale* (Segal, Silverman & Temkin, 1995) was developed from a definition of empowerment based on writings and practice theories of leaders in the self-help mental health movement and theoretical constructs in community psychology. The scale was tested with 310 members of 4 self-help organizations.

## RECOVERY IN MENTAL HEALTH SYSTEM POLICY

Anthony (1991, 1993) introduced recovery as the guiding vision for the mental health system after reading and listening to consumers' personal accounts of their struggle through and recovery from mental illness. He traces the progress of the mental health system from deinstitutionalization through the establishment of community support and rehabilitation services, with recovery envisioned as the next step in the process. Anthony notes that while deinstitutionalization focused on new uses for buildings and facilities, the community support system was planned as a network of essential services to support persons with psychiatric disabilities, and the field of psychiatric rehabilitation emphasized treating the consequences of mental illness. However, recovery speaks about how recipients of services will live and choose the services they need and want. He emphasizes that service providers must be understanding and tolerant of the range of intense emotions experienced by consumers during recovery without diagnosing behavior as abnormal or pathological. The mental health system must provide the environment that stimulates and encourages recovery (Anthony, 1993).

A number of states have included the word recovery or the concept of recovery in documents such as mission statements, guiding principles and descriptions of treatment programs. Some states are trying to incorporate recovery into the way mental health services are provided.

Ohio has been a leader in this effort. In 1993 the Ohio Department of Mental Health (ODMH) conducted a series of dialogues throughout Ohio and across the nation with consumers, family members and providers, including clinicians, to explore the philosophy of recovery and to determine elements that contribute to the recovery process. In 1994 a Recovery Conference was followed with a discussion about the importance and use of recovery in the mental health system by the Community Support Program Advisory Committee, composed of clinicians, consumers and family members. They produced the report *The Recovery Concept: Implementation in the Mental Health System* (Beale & Lambric, 1995).

The recommendations of this report were organized by the key themes of jobs, empowerment, stigma, peer support, family support, community involvement, access to resources, education, and clinical roles and relationships. Members of the state Office of Consumer Services, collaborating with other members of ODMH and the community, have continued to sponsor annual recovery conferences and recovery dialogues. They have also established regional Consumer Quality Review Teams and local collaborative partnerships through which consumers can voice their opinions about the quality and effectiveness of services and promote the development of service alternatives that best meet their needs. A result of this continued dialogue and emphasis on recovery is the development of the *Mental Health Recovery Process and Best Practices Model*, which is described in the publication *Emerging Best Practices in Mental Health Recovery* (Townsend et al., 1999).

In 1996 the Governor of Wisconsin authorized a Blue Ribbon Commission on Mental Health Care, whose purpose was to develop a long-term plan for mental health services in Wisconsin for children, adults and elderly adults. "The Blue Ribbon Commission adopted the concept of recovery, that is, the successful integra-

tion of a mental disorder into a consumer's life, as the key tenet of the redesigned mental health system" (DeSantis & The Blue Ribbon Commission, 1997, p.iii).<sup>2</sup>

In a report prepared for the Commission, Jacobson (1998) conducted semi-structured telephone interviews with key staff in 12 states, asking how they operationalized and implemented recovery in their state mental health systems. Jacobson obtained her sample by identifying states that were purported to be leaders in this area and was referred to other states through a snowball sampling process. She indicated that states are at different stages in planning and implementation and that approaches to incorporating recovery differ from state to state. "Some states seem to be repackaging their old service models (e.g., CSPs, supported education, rehabilitation services) using the recovery language; others are wholly re-inventing themselves" (p. 1).

Jacobson and Curtis (2000) summarize the findings from this study, describing the process taken by states to develop a "recovery oriented" service system and the areas or strategies selected to do this. The process is described as an effort to understand the concept of recovery and to determine its viability and value within clinical and financial constraints. The development of a vision statement is done through the establishment of a task force or work group that includes diverse stakeholders. Multiple sources of information are tapped to assist in understanding the concept and developing a vision statement incorporating a working definition of recovery and making recommendations to implement the principles identified.

Jacobson and Curtis (2000) comment:

*With vision statements in hand, some states simply rename their existing programs....Community support services, vocational rehabilitation or housing support are now described as 'recovery-oriented' services. This renaming process demonstrates a lack of understanding of recovery; in particular, a failure to acknowledge the necessity for a fundamental shift toward sharing both power and responsibility (p. 335).*

Strategies to implement and operationalize recovery in the mental health system in states that have moved beyond the service name-changing stage include:

*... education, consumer and family involvement, support for consumer operated services, emphasis on relapse prevention and management, incorporation of crisis planning and advance directives, innovations in contracting and financing mechanisms, definition and measurement of outcomes, review and revision of key policies, and stigma reduction initiatives (p. 335).*

In describing the implementation of a rehabilitation-recovery philosophy in the Illinois mental health system, Barton (1998) indicates that all of the disciplines involved in providing mental health services must collaborate with consumers, and with each other, to assist consumers in conceptualizing, setting and reaching their recovery goals. Barton summarizes: "The consumer-centered recovery philosophy is the umbrella over all models, disciplines, practices, and activities in the hospital and the community" (p. 177). Barton also recognizes the

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<sup>2</sup> Note: Most consumers who are thinking about the definition of recovery would not accept this definition.

need for professionals and policy makers to reexamine, reevaluate and redefine their own professional identity and role.

State and federal initiatives to identify successful mental health services include recovery as one of the areas that must be addressed. Although specific recovery indicators have not been identified yet, there is great interest in finding and using measures of recovery that can help the mental health system determine whether people with mental illness are experiencing improvements in their quality of life.

A draft report of work done by the National Association of State Mental Health Program Directors (NASMHPD) Technical Workgroup on Performance Indicators (1998) includes Recovery/Personhood/Hope as one of nearly 50 indicators for adults with serious mental illness. This indicator is identified as “developmental” in that there are no identified measures for this as yet, but it is deemed important enough to be included and to search for or develop some way of measuring this indicator.

State Indicator Pilot Grants were awarded by the federal Center For Mental Health Services (CMHS) to 16 states in 1998 to pilot test 32 selected performance indicators incorporated from the CMHS Five-State Feasibility Study and the NASMHPD Framework of Mental Health Performance Indicators. A subgroup of these states plans to work on the indicator for Recovery/Personhood/Hope.

In a survey of state mental health agencies about consumer involvement in state surveys, Kaufmann (1999) asked if the state included recovery in its consumer survey. Of the 49 states and territories that responded, 67 percent indicated that they did so. However, the majority of these states indicated that they defined recovery the same as the Mental Health Statistics Improvement Program (MHSIP) and used the outcome measures from the MHSIP Report Card as recovery measures. The Report Card was not developed as a measure of recovery, and is not considered an adequate measure of recovery.

Jacobson and Curtis (2000) conclude their article with several important and thought provoking questions about recovery. They are included in their entirety here because they represent the challenges faced by individuals and systems as recovery is studied and as programs and systems attempt to implement and operationalize a recovery-oriented system:

- ▣ “How can we deepen our understanding of recovery as an individual process? What stimulates and sustains the process? What hinders or smothers it? What are the best methods for answering such questions?”
- ▣ “Can recovery be measured? Should recovery be measured? What are the risks of doing so? Of not doing so?”
- ▣ “How can we transfer our knowledge about recovery as an individual process to our policy-making and service-planning activities? How do specific policies and services affect individual recovery?”

- “How will we know if we are creating a recovery-oriented system? By what criteria should the system be judged? Should we measure individual gains? Aggregate outcomes? System-level change? Over what period of time?”
- “How can we balance recovery as an individual, singular process, with the system’s need for standardization? Can we formulate a generalized concept of recovery and still respect the process as unique?”
- “For what should we hold the public mental health system accountable? Are we willing to trade off some system liability for the increased self-determination and personal responsibility that seem to be the hallmark of recovery?”
- “What barriers stand in the way of implementing a recovery orientation? What forces sustain the status quo?”
- “Should recovery be the foundational principle of the mental health system?”

Jacobson and Curtis sum up their views in this way:

*These problems start with problems of epistemology—how best to study and measure recovery. But they end in problems of politics and values—what is to be our society’s approach to helping persons with psychiatric disabilities? For recovery to herald a real change in our assumptions and practices, and to make a difference in the lives of people living with severe and persistent mental illness, it is vital that all of these questions be engaged. How we choose to answer them will shape mental health services in the coming decades (p. 339).*

## COMMENTS, SUMMARY AND CONCLUSIONS

**R**ecovery 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.

However, many consumers/survivors report that recovery is not an adequate word to describe the journey through and to overcome their mental illness, or the accompanying social consequences; nor does it describe the results or outcome of that journey. While many agree that no one term is adequate, words such as healing, transformation and overcoming have been suggested.

There are a number of activities in the area of recovery, with accompanying written material to contribute to our understanding. Personal accounts of recovery journeys written or told by consumers/survivors are one of the most important contributions to the recovery literature. Here you have not only the account of what happened but also the inner feelings, the insights and the actions taken to overcome and conquer. Some consumers/survivors have used their own and others' experiences and insights to create training and educational materials to teach others how to recover and manage their lives. Thus opportunities are provided to learn how to overcome and to manage on a daily basis. Research on recovery is increasing. This includes efforts to define recovery more concretely, to find out whether and to what degree consumers agree with these definitions, to determine what outcomes are possible and to develop measurements of this phenomenon. Finally, efforts are being made at the state and federal levels to create a recovery-oriented environment in the provision of mental health services and to hold providers of mental health services accountable for doing so.

Attempts to measure recovery or aspects related to recovery are very recent, and work in this area is only beginning to be published or presented at conferences. It is refreshing to hear that recovery measures are being developed in collaboration with consumers, although the extent of the collaboration has not generally been specified. There is little information about change over time or use of the instruments with specific interventions. Further work is needed in using these instruments to measure the effects of specific interventions and to measure the course of recovery with assistance from the mental health system. This needs to be done in a thorough fashion by consumer researchers in collaboration with consumer advocates, consumer policy experts and consumers who are currently using mental health services. It is also important to review the impact of culture and geography on recovery and to study how the measurement of recovery can be sensitive to these aspects.

Consumers/survivors who live "normal" lives feel they have accomplished a great deal by overcoming both their illness and the barriers they have faced. While they welcome and recommend a recovery environment in the mental health system, they are reluctant to have the mental health system "label" people as "recovered" and thus have "evidence" to remove the psychological and psychosocial supports that are necessary for them to remain well. The measurement of recovery is not only a complex task, but it also raises questions about whether this measurement gives the mental health system a tool to withdraw services from people who are "recovered" by some standard.

Although recovery activities and literature are increasing at an enormous pace, it is still a young and tender concept that is not fully developed. Achieving a recovery-oriented public mental health system will take a tremendous amount of dialogue, study, listening to each other and implementing the actual precepts of recovery including working together; treating each other with respect and dignity; and allowing, helping and encouraging consumers/survivors to “stay in the driver’s seat” and take control of their lives.

## RECOMMENDATIONS

The most important recommendation is that consumers/survivors, researchers and policy makers work together and learn from one another. Non-consumers need to read and listen to personal accounts of those who have experienced recovery, and to hear and value the opinions of consumers/survivors even if they are not fully versed in the methodology or politics of research and policy. The questions posed by Jacobson and Curtis (2000) included above must be addressed *together* by all of us who are dedicated to making life better for those who face the challenge of mental illness.

Another important area for research is the development and testing of measurement tools. This must be done in full collaboration with consumers/survivors. Although a number of instruments are already developed, they need further testing to determine if they are applicable to diverse populations and whether they measure change over time.

Although it is important to continue to study outcomes of the interventions developed and provided by the mental health system, this is difficult to do in any comprehensive way until the definition(s) of recovery are more precise and measurement tools have been developed and tested. However, this should not deter mental health agencies from searching for ways to implement this paradigm shift to a recovery environment.

There is also a need for systematic and consistent reporting of mental health system attempts and successes in implementing a recovery environment. Success will only come when knowledge about what works is exchanged and when leadership learns from others and implements what they have learned in their own systems.

Finally, there is a need to continue the collection, review and cataloging of recovery literature, both published and unpublished. Many individuals and organizations now have their own collections, but there is no central repository for a complete collection. There needs to be a central library to house this collection, along with facilities and continuous funding for both periodic review and dissemination of recovery literature. If we are ignorant of the work and discoveries of others, we cannot progress to greater heights in the development of knowledge or deepen our understanding of this most important concept, which can change lives and improve society.

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P, C	<p>Laubscher, Janie (2002). <i>Applying For Social Security Disability Benefits - A Self-Help Guide</i>. About.com  <a href="http://arthritis.about.com/library/weekly/aa083100a.htm">http://arthritis.about.com/library/weekly/aa083100a.htm</a></p>
C	<p>Lovejoy, M. (?). Organizing and Operating a Speakers' Bureau. (mhselfhelp.org)  <a href="http://mhselfhelp.org/pubs/speaker.html">http://mhselfhelp.org/pubs/speaker.html</a></p>
P	<p>MacDonald-Wilson, K., Rogers, E.S., &amp; Massaro, J. (2003). Identifying Relationships Between Functional Limitations, Job Accommodations, and Demographic Characteristics of Persons with Psychiatric Disabilities. <i>Journal of Vocational Rehabilitation</i>, 18, 15-24.  <a href="http://www.bu.edu/cpr/catalog/articles/2003/macwils2003.pdf">http://www.bu.edu/cpr/catalog/articles/2003/macwils2003.pdf</a></p>
P	<p>McGrath, P. and Jarrett, V. (2004). A Slab Over My Head: Recovery Insights From a Consumer's Perspective. <i>International Journal of Psychosocial Rehabilitation</i>, 9(1), 61-78.  <a href="http://www.psychosocial.com/IJPR_9/A_Slab.html">http://www.psychosocial.com/IJPR_9/A_Slab.html</a></p>
P, C	<p>McLean, A. (2003). "Recovering" Consumers and a Broken Mental Health System in the United States: Ongoing Challenges for Consumers/Survivors and the New Freedom Commission on Mental Health. <i>International Journal of Psychosocial Rehabilitation</i>, 8, 47-68.  <a href="http://www.psychosocial.com/IJPR_8/Recovering-McLean.html">http://www.psychosocial.com/IJPR_8/Recovering-McLean.html</a></p>

C = primarily consumer, P = primarily provider, C, P = both but weighted for consumer, P, C = both but weighted for provider  
 \* Author's pick

P	McQuiston, H.L., Goisman, R.M. & Tennison Jr., C.R. (2000). <i>Psychosocial Rehabilitation: Issues and Answers for Psychiatry</i> . <a href="http://www.wpic.pitt.edu/aacp/finds/psychosocial.html">http://www.wpic.pitt.edu/aacp/finds/psychosocial.html</a>
* P, C	Mead, S. & Copeland, M.E. (2000). What Recovery Means To Us. <i>Community Mental Health Journal</i> , 36(3), 315-328. <a href="http://mentalhealthrecovery.com/art_recoverymeans.html">http://mentalhealthrecovery.com/art_recoverymeans.html</a>
P	Muesser, K.T.; Corrigan, P.W.; Hilton, D.W.; Tanzman, B.; Schaub, A.; Gingerich, S.; Essock, S.; TARRIER, N.; Morey, D.; Vogel-Scibilia, S.; and Herz, M.I. (2002). Illness Management and Recovery: A Review of the Research. <i>Psychiatric Services</i> , 53(10), 1272-1284. <a href="http://www.mentalhealthpractices.org/pdf_files/mueser.pdf">http://www.mentalhealthpractices.org/pdf_files/mueser.pdf</a>
C, P	National Empowerment Center (1999). <i>10 Ways to De-Stress Your Life</i> . www.power2u.org. <a href="http://www.power2u.org/selfhlep/10ways.html">http://www.power2u.org/selfhlep/10ways.html</a>
C	National Consumer Supporter Technical Assistance Center (?). <i>Fundraising Basics</i> . National Mental Health Association. (ncstac.org). <a href="http://www.ncstac.org/content/materials/funds.pdf">http://www.ncstac.org/content/materials/funds.pdf</a>
C	National Consumer Supporter Technical Assistance Center (?). <i>Guide to Proposal Writing</i> . National Mental Health Association. (ncstac.org). <a href="http://www.ncstac.org/content/materials/proposal.pdf">http://www.ncstac.org/content/materials/proposal.pdf</a>
C	National Consumer Supporter Technical Assistance Center (?). <i>How to Develop and Maintain a Consumer Advisory Board</i> . National Mental Health Association. (ncstac.org). <a href="http://www.ncstac.org/content/materials/cab.pdf">http://www.ncstac.org/content/materials/cab.pdf</a>
C	National Consumer Supporter Technical Assistance Center (?). <i>How to Establish 501(c) (3) Status</i> . National Mental Health Association. (ncstac.org). <a href="http://www.ncstac.org/content/materials/501c3.pdf">http://www.ncstac.org/content/materials/501c3.pdf</a>
C	National Mental Health Consumers' Self-Help Clearinghouse (unknown). <i>Consumer-run Drop-in Centers</i> . Philadelphia, PA: NMHCSHC <a href="http://mhselfhelp.org/pubs/dropin.pdf">http://mhselfhelp.org/pubs/dropin.pdf</a>
C	National Mental Health Consumers' Self-Help Clearinghouse (unknown). <i>Raising Money for a Self-Help/Advocacy Group</i> . Philadelphia, PA: NMHCSHC. <a href="http://mhselfhelp.org/pubs/raising.pdf">http://mhselfhelp.org/pubs/raising.pdf</a>
C	National Mental Health Consumers' Self-Help Clearinghouse (unknown). <i>Consumer-run Businesses and Services</i> . Philadelphia, PA: NMHCSHC. <a href="http://mhselfhelp.org/pubs/business.pdf">http://mhselfhelp.org/pubs/business.pdf</a>

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C	National Mental Health Consumers' Self-Help Clearinghouse (unknown). <i>Self-Advocacy</i> . Philadelphia, PA: NMHCSHC. <a href="http://www.mhselfhelp.org/freedom/pubsa.pdf">http://www.mhselfhelp.org/freedom/pubsa.pdf</a>
C	National Mental Health Consumers' Self-Help Clearinghouse (unknown). <i>Serving on Boards and Committees</i> . Philadelphia, PA: NMHCSHC. <a href="http://mhselfhelp.org/pubs/boards.pdf">http://mhselfhelp.org/pubs/boards.pdf</a>
C	National Mental Health Consumers' Self-Help Clearinghouse (2000). <i>Systems Advocacy</i> . Philadelphia, PA: NMHCSHC <a href="http://mhselfhelp.org/pubs/systems.pdf">http://mhselfhelp.org/pubs/systems.pdf</a>
C, P	National Mental Health Consumers' Self-Help Clearinghouse (unknown). <i>Advocacy and Recovery Using the Internet</i> . Philadelphia, PA: NMHCSHC. <a href="http://mhselfhelp.org/pubs/internet.pdf">http://mhselfhelp.org/pubs/internet.pdf</a>
P, C	Ohio Developmental Disabilities Council (?). <i>Ohio's Medicaid Buy-In Campaign: Advocacy Planning Guide</i> . <a href="http://www.ohioadvocates.org/Medicaid%20Buy-in%20Guide.pdf">http://www.ohioadvocates.org/Medicaid%20Buy-in%20Guide.pdf</a>
* C	Ohio Legal Rights Service (2004). <i>Your Mental Health Rights: How They Protect and Support Your Recovery</i> . <a href="http://olrs.ohio.gov/other/YourMHRightsHandbook.pdf">http://olrs.ohio.gov/other/YourMHRightsHandbook.pdf</a>
P	Ohio Mental Health Commission (2001). <i>Changing Lives: Ohio's Action Agenda for Mental Health</i> . Ohio Department of Mental Health, Columbus, Ohio. <a href="http://www.mh.state.oh.us/initiatives/mhcommission/changing-lives01162001.pdf">http://www.mh.state.oh.us/initiatives/mhcommission/changing-lives01162001.pdf</a>
* P	Onken, S.; Dumont, J.; Ridgeway, P.; Dornan, D. and Ralph, R. (2002). <i>Mental Health Recovery: What Helps and What Hinders?</i> NASMHPD and NTAC. <a href="http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/MHSIPReport.pdf">http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/MHSIPReport.pdf</a>
* C	Peterson, C., Jonikas, J, Cook, J. and Priester, F. (2003). <i>Raising Difficult Issues With Your Service Provider</i> . University of Illinois at Chicago. <a href="http://www.psych.uic.edu/uicnrtc/raisingissues.pdf">http://www.psych.uic.edu/uicnrtc/raisingissues.pdf</a>
P	Ragins, M. (2002). <i>An Empowerment Revolution Plan</i> . The Village Website (www.village-isa.org). <a href="http://www.village-isa.org/Ragin's%20Papers/empower.%20rev.%20plan.htm">http://www.village-isa.org/Ragin's%20Papers/empower.%20rev.%20plan.htm</a>
* P	Ragins, M. (2002). <i>Recovery With Severe Mental Illness: Changing From A Medical Model to A Psychosocial Rehabilitation Model</i> . The Village Website (www.village-isa.org). <a href="http://www.village-isa.org/Ragin's%20Papers/recov.%20with%20severe%20MI.htm">http://www.village-isa.org/Ragin's%20Papers/recov.%20with%20severe%20MI.htm</a>

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P	Ragins, M. (?) <i>The Four Walls</i> . The Village. <a href="http://www.village-isa.org/Ragins's%20Papers/four_walls.htm">http://www.village-isa.org/Ragins's%20Papers/four_walls.htm</a>
P	Ragins, M. (?). <i>Sewing a Mental Illness Recovery Banner</i> . The Village. <a href="http://www.village-isa.org/Ragins's%20Papers/Sewing%20a%20MI%20recov.%20banner.htm">http://www.village-isa.org/Ragins's%20Papers/Sewing%20a%20MI%20recov.%20banner.htm</a>
P	Russinova, Z. (1999). Providers' Hope-Inspiring Competence as a Factor Optimizing Psychiatric Rehabilitation Outcomes. <i>Journal of Rehabilitation</i> , 16(4), 50-57. (Center for Psychiatric Rehabilitation, Boston). <a href="http://www.bu.edu/cpr/catalog/articles/1999/russinova1999.pdf">http://www.bu.edu/cpr/catalog/articles/1999/russinova1999.pdf</a>
P, C	Sabin, J.E. and Daniels, N. (2003). Strengthening the Consumer Voice in Managed Care: VII. The Georgia Peer Specialist Program. <i>Psychiatric Services</i> , 54(4), 497-498. <a href="http://psychservices.psychiatryonline.org/cgi/reprint/54/4/497">http://psychservices.psychiatryonline.org/cgi/reprint/54/4/497</a>
C, P	Samples, K. (2001). <i>Online and Off the Street: Homeless Man Reboots His Life</i> . Cincinnati Enquirer; Cincinnati, OH. <a href="http://enquirer.com/editions/2001/02/18/loc_online_and_off.html">http://enquirer.com/editions/2001/02/18/loc_online_and_off.html</a>
P	Satcher, D. (1999) <i>Mental Health: A Report of the Surgeon General</i> . Surgeongeneral.gov <a href="http://www.surgeongeneral.gov/library/mentalhealth/home.html">http://www.surgeongeneral.gov/library/mentalhealth/home.html</a>
* C, P	Sesula, D. (?) <i>You and Me</i> . (poem; power2u.org). <a href="http://www.power2u.org/empower/you_and_me.html">http://www.power2u.org/empower/you_and_me.html</a>
* C, P	Schmook, A. (?). <i>They Said I Would Never Get Better</i> . From "The Experience of Recovery" edited by LeRoy Spaniol and Martin Koehler. <a href="http://www.mhrecovery.com/Andrea.htm">http://www.mhrecovery.com/Andrea.htm</a>
P, C	Solomon, P. (2004). Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients. <i>Psychiatric Rehabilitation Journal</i> , 27(4), 392-401. On the Boston Center for Psychiatric Rehabilitation journal website. <a href="http://www.bu.edu/prj/spring2004/PRJ-27.4%20Peer%20Support.pdf">http://www.bu.edu/prj/spring2004/PRJ-27.4%20Peer%20Support.pdf</a>
C, P	Spaniol, L. & Gagne, C. (1997). Acceptance: Some Reflections. <i>Psychiatric Rehabilitation Journal</i> , 20(3), 75-77. <a href="http://www.bu.edu/cpr/catalog/articles/1997/spaniol-gagne1997.pdf">http://www.bu.edu/cpr/catalog/articles/1997/spaniol-gagne1997.pdf</a>
P	Substance Abuse and Mental Health Services Administration (2003). <i>Strategies for Developing Treatment Programs for People with Co-Occurring Substance Abuse and Mental Disorders</i> . SAMHSA Publication No. 3782. Rockville, MD: SAMHSA. <a href="http://www.nccbh.org/cooccurringreport.pdf">http://www.nccbh.org/cooccurringreport.pdf</a>
P	Sullivan, W. P. (1994). A Long and Winding Road: The Process of Recovery from Severe Mental Illness. <i>Innovations &amp; Research</i> , 3(3), 19-27. <a href="http://www.bu.edu/cpr/recovery/articles/sullivan1994.pdf">http://www.bu.edu/cpr/recovery/articles/sullivan1994.pdf</a>

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\* Author's pick

C	TenHoor, W. & Associates (2002). <i>A Guide for Consumer Organization Leadership: Principles for Practice</i> . National Empowerment Center. Lawrence, MA: NEC. (power2u.org). <a href="http://power2u.org/Guide-Final.pdf">http://power2u.org/Guide-Final.pdf</a>
* P, C	The President's New Freedom Commission on Mental Health (2003). <i>Achieving the Promise: Transforming Mental Health Care in America</i> . (final report). <a href="http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf">http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf</a>
C, P	The Story Bin (?) <i>A Place to Stand</i> . <a href="http://www.storybin.com/words/words110.shtml">http://www.storybin.com/words/words110.shtml</a>
P	Torrey, W. C.; Drake, R. E.; Dixon, L.; Burns, B. J.; Flynn, L.; Rush, A. J.; Clark, R. E.; and Klatzker, D. (2001). Implementing Evidence-Based Practices for Persons with Severe Mental Illnesses. <i>Psychiatric Services</i> , 52(1), 45-50. <a href="http://www.mentalhealthpractices.org/pdf_files/torrey.pdf">http://www.mentalhealthpractices.org/pdf_files/torrey.pdf</a>
C, P	Tucker-Ladd, C. (1996) <i>Psychological Self-Help</i> (online book). Mental Health Net. <a href="http://mentalhelp.net/psyhelp/">http://mentalhelp.net/psyhelp/</a>
P, C	Walsh, D. (1996). A Journey Toward Recovery: From the Inside Out. <i>Psychiatric Rehabilitation Journal</i> , 20(2), 85-89.
C, P	Whitehead, T. (?) <i>A Recovery Story</i> . (mentalhealthrecovery.com) <a href="http://mentalhealthrecovery.com/art_recovery.html">http://mentalhealthrecovery.com/art_recovery.html</a>
C, P	Wilkinson, A. (?). <i>We are More than Our Disorder</i> . (power2u.org) <a href="http://www.power2u.org/empower/our_disorder.html">http://www.power2u.org/empower/our_disorder.html</a>
C, P	Williams, X. (1999). <i>Advance Directives Are What You Make Them</i> . NEC. <a href="http://www.power2u.org/selfhlep/directives.html">http://www.power2u.org/selfhlep/directives.html</a>

**Additional Off-line Resources:**

P	Alverson, H., Alverson, M., Drake, R.E., and Becker, D.R. (1998). Social Correlates Of Competitive Employment Among People With Severe Mental Illness. <i>Psychiatric Rehabilitation Journal</i> , 22(1), 34-40.
* P	Anthony, W.A., Cohen, M., Farkas, M. & Gagne, C. (2002). <i>Psychiatric Rehabilitation (4th ed.)</i> . Boston, MA: Boston University.
P	Anthony, W.A., Brown, M.A., Rogers, E.S., and Derringer, S. (1999). A Supported Living/Supported Employment Program For Reducing The Number of People In Institutions. <i>Psychiatric Rehabilitation Journal</i> , 23(1), 57-61.

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\* Author's pick

P	Arns, P., Rogers, E.S., Cook, J., Mowbray, C. & members of the IAPSRs Research Committee (2001). The IAPSRs Toolkit: Development, Utility, And Relation To Other Performance Measurement Systems. <i>Psychiatric Rehabilitation Journal</i> , 25(1), 43-52.
* C, P	Balter, M. & Katz, R. (1987). <i>Nobody's Child</i> . Cambridge, MA: Perseus Books.
P	Beale, V. & Lambric, T. (1995). <i>The Recovery Concept: Implementation in the Mental Health System</i> . Columbus, OH: ODMH.
C, P	Burns, D.D. (1999). <i>The Feeling Good Handbook (revised)</i> . New York: Penguin Books.
C, P	Burns, D.D. (1999). <i>Feeling Good: The New Mood Therapy (revised)</i> . New York: Signet Books.
P	Burns-Lynch, B. & Salzer, M.S. (2001). Adopting Innovations - Lessons Learned from a Peer-Based Hospital Diversion Program. <i>Community Mental Health Journal</i> , 37(6), 511-521.
P	Bussema, K.E. & Bussema, E.F. (2000). Is There a Balm in Gilead? The Implications of Faith In Coping With A Psychiatric Disability. <i>Psychiatric Rehabilitation Journal</i> , 24(2), 117-124.
P	Byrne, C., Brown, B., Voorberg, N., Schofield, R., Browne, G., Gafni, A., Schuster, M., Watt, S., Roberts, J. & Hoxby, H. (1999). Health Education Or Empowerment Education With Individuals With A Serious Persistent Psychiatric Disability. <i>Psychiatric Rehabilitation Journal</i> , 22(4), 368-380.
C, P	Caldwell, D.W. (2002). <i>No More Secrets</i> . Rock Hill, SC: Overcomer Press.
C, P	Chamberlin, J. (1998). Citizens Rights and Psychiatric Disability. <i>Psychiatric Rehabilitation Journal</i> , 21(4), 405-408.
P	Chandler, D., Levin, S. & Barry, P. (1999). The Menu Approach To Employment Services: Philosophy And Five-Year Outcomes. <i>Psychiatric Rehabilitation Journal</i> , 23(1), 24-33.
P	CMHS (unknown). <i>Partners in Recovery: Creating Successful Practitioner-Consumer Alliances (video)</i> . CMHS.
C, P	Copeland, M.E. (1999). <i>Winning Against Relapse</i> . Oakland, CA: New Harbinger Publications, Inc.
* C, P	Copeland, M.E. (2000). <i>Wellness Recovery Action Plan (revised edition)</i> . West Dummerston, VT: Peach Press.

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 \* Author's pick

C, P	Copeland, M.E. (2000). <i>The Loneliness Workbook</i> . Oakland, CA: New Harbinger Publications, Inc.
C, P	Cousins, N. (1981). <i>Anatomy of an Illness: As Perceived by the Patient</i> . New York: Bantam Books.
P, C	Deegan, P.E. (unknown). Beyond the Coke and Smoke Syndrome: Working With People Who Appear Unmotivated (video). Lawrence, MA: National Empowerment Center.
C, P	Deegan, P. (1988). Recovery: The Lived Experience of Rehabilitation. <i>Psychosocial Rehabilitation Journal</i> , 11(4), 11-19.
C, P	Deegan, P. (1992). The Independent Living Movement And People With Psychiatric Disabilities: Taking Back Control Over Our Own Lives. <i>Psychosocial Rehabilitation Journal</i> , 15(3), 3-19.
P	Drake, R. E., Bond, G. R., & Torrey, W. C. (2000). Psychiatry and Rehabilitation. <i>Community Mental Health Journal</i> , 36(6), 617-618.
* C, P	Dual Recovery Anonymous (1993). <i>The Dual Disorders Recovery Book: A Twelve Step Program For Those With Addiction And An Emotional Or Psychiatric Illness</i> . Center City, MN: Hazelden.
C	Fisher, D.B. (?). <i>New Vision of Recovery: You Too Can Recover From "Mental Illness"</i> . Lawrence, MA: National Empowerment Center.
* C, P	Hamilton, T. & Samples, P. (1994). <i>The 12 Steps and Dual Disorders: A Framework of Recovery For Those Of Us With Addiction &amp; An Emotional Or Psychiatric Illness</i> . Center City, MN: Hazelden.
* C, P	Hamilton, T. & Samples, P. (1994). <i>The 12 Steps and Dual Disorders: A Framework of Recovery For Those Of Us With Addiction &amp; An Emotional Or Psychiatric Illness (Workbook)</i> . Center City, MN: Hazelden.
P, C	Holter, M.C., Mowbray, C.T., Bellamy, C.D., MacFarlane, P. and Dukarski, J. (2004). Critical Ingredients of Consumer Run Services: Results of a National Survey. <i>Community Mental Health Journal</i> , 40(1), 47-63.
* P	Jacobson, N. & Curtis, L. (2000). Recovery As Policy In Mental Health Services: Strategies Emerging From the States. <i>Psychiatric Rehabilitation Journal</i> , 23(4), 333-341.
P	Kirsh, B. (2000). Factors Associated With Employment For Mental Health Consumers. <i>Psychiatric Rehabilitation Journal</i> , 24(1), 13-21.
P	Lehman, A.F. (2000). Putting Recovery into Practice: A Commentary on "What Recovery Means to Us." <i>Community Mental Health Journal</i> , 36(3), 329-331.

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P	Manning, S.S., Brinkman, E., Burgess, D.D., Lucero, L., Quarton, B., Quarton, D.J. & Smith, V.P. (2000). The CHARG Experience With Consumer-Professional Partnership. <i>Psychiatric Rehabilitation Journal</i> , 24(2), 125-134.
P	Marsh, D.T., Koeske, R.D., Schmidt, P.A., Martz, D.P. & Redpath, W.B. (1997). In L. Spaniol, C. Gagne & M. Koehler (Eds.), <i>Psychological And Social Aspects of Psychiatric Disability</i> (pp.358-369). Boston: Boston University.
P, C	Mason, K., Olmos-Gallo, A., Bacon, D., McQuilken, M., Henley, A., and Fisher, S. (2004). Exploring the Consumer's and Provider's Perspective on Service Quality in Community Mental Health Care. <i>Community Mental Health Journal</i> , 40(1), 33-46.
* C, P	Mc, Tim (1995). <i>Today I Will Do One Thing</i> . Center City, MN: Hazelden.
* P	O'Hara, A. & Cooper, E. (2002). <i>Section 8 Made Simple: Using The Housing Choice Voucher Program To Assist People With Disabilities</i> . Technical Assistance Collaborative, Inc., Boston, MA.
C, P	Ohio Department of Mental Health (2000). <i>Advance Directives</i> . Columbus, OH: ODMH.
P	Ralph, R.O., Kidder, K. & Phillips, D. (2000). <i>Can We Measure Recovery? A Compendium of Recovery and Recovery-Related Instruments</i> . Cambridge, MA: Evaluation Center @ HSRI.
P	Regenold, M., Sherman, M.F. & Fenzel, M. (1999). Getting Back To Work: Self-Efficacy As A Predictor of Employment Outcome. <i>Psychiatric Rehabilitation Journal</i> , 22(4), 361-367.
P	Segal, S.P., Silverman, C. & Temkin, T. (1995). Measuring Empowerment in Client-Run Self-Help Agencies. <i>Community Mental Health Journal</i> , 31(3), 215-227.
P	Smith, M.K. (2000). Recovery From A Severe Psychiatric Disability: Findings Of A Qualitative Study. <i>Psychiatric Rehabilitation Journal</i> , 24(20), 149-158.
* C, P	Spaniol, L., Bellingham, R., Cohen, B., & Spaniol, S. (2003). <i>The Recovery Workbook II: Connectedness</i> . Boston, MA: Boston University.
* P, C	Spaniol, L., Bellingham, R., Cohen, B., & Spaniol, S. (2003). <i>Leader's Guide to The Recovery Workbook II: Connectedness</i> . Boston, MA: Boston University.
P	Spaniol, L., Brown, M.A., Blankertz, L., Burnham, D.J., Dincin, J., Furlong-Norman, K., Nesbitt, N., Ottenstein, P., Prieve, K., Rutman, I. & Zipple, A. (eds) (1994). <i>An Introduction To Psychiatric Rehabilitation</i> . Columbia, MD: IAPSRs.

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* C, P	Spaniol, L., Koehler, M., Hutchinson, D. (1994). <i>The Recovery Workbook: Practical Coping and Empowerment Strategies for People with Psychiatric Disability</i> . Boston, MA: Boston University.
* P, C	Spaniol, L., Koehler, M., Hutchinson, D. (2000). <i>The Recovery Workbook: Practical Coping and Empowerment Strategies for People with Psychiatric Disability (Leader's Guide)</i> . Boston, MA: Boston University.
* C, P	Spaniol, L. & Koehler, M., eds (1994). <i>The Experience of Recovery</i> . Boston: Boston University Press.
P	Starks, R.D., Zahniser, J.H., Maas, D. & McGuirk, F. (2000). The Denver Approach To Rehabilitation Services. <i>Psychiatric Rehabilitation Journal</i> , 24(1), 59-64.
P	Technical Assistance Collaborative (?). <i>Federal Housing Resource Guide</i> . TAC., Boston, MA.
P	Torrey, W.C., Mead, S. & Ross, G. (1998). Addressing The Social Needs Of Mental Health Consumers When Day Treatment Programs Convert To Supported Employment: Can Consumer-Run Services Play a Role? <i>Psychiatric Rehabilitation Journal</i> , 22(1).
P, C	Townsend, W., Boyd, S. & Griffin, G. (1999). <i>Emerging Best Practices in Mental Health Recovery</i> . Columbus, OH: Ohio Department of Mental Health.
C, P	Wahl, O.F. (1999). <i>Telling is Risky Business</i> . New Brunswick, NJ: Rutgers University Press.
P	Weingarten, R., Chinman, M., Tworkowski, S., Stayner, D. & Davidson, L. (2000). The Welcome Basket Project: Consumers Reaching Out to Consumers. <i>Psychiatric Rehabilitation Journal</i> , 24(1), 65-68.
* C, P	Wolter, D.L. (1989). <i>A Life Worth Waiting For: Messages From A Survivor</i> . Minneapolis, MN: CompCare Publishers.
P	Yanos, P.T., Primavera, L.H. & Knight, E.L. (2001). Consumer-Run Service Participation, Recovery of Social Functioning, and the Mediating Role of Psychological Factors. <i>Psychiatric Services</i> , 52(4), 493-500.

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 \* Author's pick

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**Building Mental Health Service Act Programs**  
**By Mark Ragins, MD**

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## Introduction

It's been a very busy year or so since I posted my "Proposition 63 Begins Implementation Toolbox" in early 2005. Like many of you, I've participated in a lot of recovery-based planning meetings. I've been to 22 counties around the state doing workshops and consultations. I've also been working regularly with the "Big 7" clinics in Los Angeles, along with Bruce Anderson. These are large directly county operated clinics with very high case loads. We've been facilitating a recovery based cultural transformation so that as MHSA money becomes available, it will be incorporated into already transforming programs. You've all taught me a great deal and treated me very well.

I've kept writing over the course of the year, and now that counties are beginning to get their plans approved and getting ready to spend some money, building some new programs and hiring some new staff, it seemed like a good idea to post this set of "program building" writings. They are all separate papers, not connected chapters. Some build on older writings and some are entirely new.

For those of you who are my long term readers, you may have noticed that my major writings are focused on four areas of recovery transformation:

- **A Road to Recovery** contains a description of the recovery process itself with lots of my stories.
- **A Guide to Mental Health Transformation on a Personal Level** contains a description of the personal transformations needed from consumers and their families, staff, programs and their leaders, systems and their administrators and auditors, and the community.
- **Proposition 63 Begins Implementation Toolbox** contains a set of papers and tools about recovery based system design.
- **Building Mental Health Services Act Programs** contains a set of papers and tools about recovery based program implementation.

They're all on the Village's website [www.village-isa.org](http://www.village-isa.org) along with some other writings on special topics. I hope they're helpful to you. I love to hear from readers so feel free to e-mail me at [mragins@mhala.org](mailto:mragins@mhala.org).

## **Implementing the Mental Health Services Act**

By Mark Ragins, MD

Everything keeps moving along with the Mental Health Services Act. Lot's of planning, including many new voices, has happened. Plans have been written and approvals are coming down from the state. We're getting to the point of writing new contracts, hiring new staff, creating some new programs and transforming some old ones. There's a lot of work to be done. We have to be careful if we're going to succeed in building recovery.

As we've moved around the state doing lots of trainings, we've found that things are getting very complicated. Different counties and programs are at different points and different people within each county and program are at different points. We're trying to put together a picture of the larger path we're all on so people will know what to focus on next.

The first step is to build exposure and enthusiasm about recovery. This may seem like stuff you've already done, especially if you've been sitting in endless stakeholder and planning meetings, but remember, many of the people you're going to be asking to do the actual work and many of the consumers and their families who will be effected, haven't been to those meetings with you and may need to be brought up to speed.

### ***Discussion questions:***

- 1) How can everyone become aware of the basics of recovery (e.g. consumer stories, recovery research, consumer movement and other contributions, principles of recovery, consumer and family inclusion, quality of life outcomes, contrasts with the medical model)?***
- 2) How can everyone identify how recovery resonates with them and could promote some of their core values?***
- 3) How can everyone tell their own recovery worker stories, identify their strengths as a recovery worker and also identify what they'd like to enhance?***

The second step is to build believability and motivation. Many people, who nodded politely when told about recovery, will have some serious questions and reservations now that it's becoming real. They may not believe your system works well enough to actually build anything positive. They may not believe your leaders or the culture of your programs can ever change. They may not want to change themselves. We need to hear these concerns and create a vision they can buy into, that they think is realistic, so they'll get involved.

### ***Discussion questions:***

- 4) How can everyone believe recovery is actually going to happen instead of just the latest fashion to be waited out?***
- 5) How can everyone believe their system can change enough to bring recovery to the table as an important factor in administrative decision making alongside cost control, revenue generation, risk management, personal politics, and clinical treatment promotion?***
- 6) How can everyone believe their leaders are really invested in making this transformation work instead of pretending to do this to get the money?***
- 7) How can everyone believe the line staff is both willing and able to become recovery workers?***

- 8) *How can everyone believe that they'll work together towards the mission of recovery instead of looking out for their own personal gain and comfort?*
- 9) *How can everyone understand the changes needed at the program level to achieve this transformation?*
- 10) *How can everyone visualize where they fit into a recovery based spectrum of services?*

The third step is to build action. People have to create action plans that they own to start actually building. We can give them recovery based goals and a clear idea of what they're trying to build, but they're the experts in their own lives. They have to build on their own strengths and find the best way for them.

***Discussion questions:***

- 11) *How can line staff become willing and able to create and implement their own action plans within their clinic instead of being expected to follow orders from above?*
- 12) *How can staff form teams in their own clinics to make decisions, take risks, act, and learn from what they've tried?*
- 13) *How can program leaders champion and shepherd substantive changes in how things are done?*
- 14) *How can administration alter policies and procedures, working with unions, risk management, and payors to facilitate recovery based changes?*
- 15) *How can open and trusting lines of communication and collaboration between line staff, program leaders, and administration be created that flow both top down and bottom up?*
- 16) *How can consumers and families be included in the transformation process working alongside line staff, program leaders, and administrators?*
- 17) *How can everyone plan and make changes at the program level in staff values, staff-consumer interactions, infrastructure, and service capacity?*
- 18) *How can motivation and energy be maintained through the long and difficult implementation process?*
- 19) *How can administration actively support the transformation process by changing department mission, policies and procedures, hiring practices, outcome accountability infrastructure, and billing/productivity requirements?*

The fourth step is to build technical expertise. You may be building services or programs or cultures you've never built before. You may be hiring people you've never hired before. You may be asking consumers and their families to do things they've never done before. We can help move beyond vision to building new skills.

***Discussion questions:***

- 20) *How can staff obtain and utilize recovery expertise to best implement changes at the program level in staff values, staff-consumer interactions, infrastructure, and service capacity?*
- 21) *How can administration obtain and utilize recovery expertise to best support the transformation process by changing department mission, policies and procedures, hiring practices, outcome accountability infrastructure, and billing/productivity requirements?*
- 22) *How can staff with needed new skills including recovery promotion, housing, employment, education, benefits assistance and financial planning, dual diagnosis competency,*

*community development and integration, wellness promotion, and graduation be trained and hired?*

- 23) *How can existing staff learn new skills and transformed roles to promote recovery most effectively?*
- 24) *How can teams of unfamiliar partners including psychiatrists, paraprofessionals, consumer and family staff and licensed clinical case managers be created and learn to work together collaboratively?*

The fifth step is to build sustainability. You need to make the new ways stick and not just slide back. You need to create structures and rituals to keep things going. Future leaders will have to maintain the transformation and promote further growth despite ongoing outside pressures. You will have to make changes in your administrative structures, leadership, programs, and your cultures and values to keep things going strong.

*Discussion questions:*

- 25) *How can the system keep recovery at the table as an important factor in administrative decision making alongside cost control, revenue generation, risk management, personal politics, and clinical treatment promotion?*
- 26) *How can funding sources be altered and used differently so they promote instead of undermine recovery?*
- 27) *How can “outsiders” be incorporated into leadership, current leaders be sustained, and career ladders be built to create new generations of leaders?*
- 28) *How can employee, consumer and family orientations be created to initiate new people into the culture and practice of the program?*
- 29) *How can rituals be created to celebrate a range of successes?*
- 30) *How can programs be protected from the destructive effects of politics and budget negotiations?*
- 31) *How can an ongoing learning culture be created and sustained, always pursuing improvement and innovation?*
- 32) *How can consumers’ goals be regularly given primacy over staff and system goals?*

It can seem like an overwhelming amount of work to do, but the more of these process and infrastructure factors are built into the transformation process as you go along the greater the likelihood the transformation will succeed.

## **What's Really Different About Recovery?** **A Personal Commentary About the Transformation Process**

By Mark Ragins, MD

All over the country, but especially in California, there are thousands of mental health professionals who have been generally minding their own business, working hard or not, comfortable or frustrated, who are now being told by a small army of advocates like me that their lives are about to change. A total transformation is under way, we claim, waving copies of the President's Commission Report and the Mental Health Services Act. The old ways are on their way out and recovery is on its way in.

Having seen many advocates come and go over the years, some with quite good ideas, our audiences are understandably skeptical. If we really want to help, you tell us, instead of preaching this recovery stuff, do something about crushing case loads, or burdensome paperwork, or unresponsive bureaucracies, or billing requirements, or restrictive civil rights laws. Is recovery going to help with any of that? Well, maybe.

What is this recovery, anyway? The answer seems to depend a lot on who's doing the talking. One of the reasons recovery has grown so strong is that it has brought together a number of powerful strands into one cord. There are the 12 step people talking about integrating mental health and substance abuse treatment, harm reduction, and motivational interviewing. There are the consumer movement people talking about empowerment and consumer-driven care, inclusiveness and choice, hiring consumers and self-help. There are rehabilitation people talking about quality of life outcomes, skill building, and employment. There are community integration people and emotional healing people, civil rights advocates and recovering staff, cultural competency people and spirituality people. There are psychiatrists talking about medication collaboration instead of medication compliance and social workers talking about community development instead of individual therapy. As the cacophony grows, any reasonable definition of recovery seems to get further and further away.

Finally something someone says sounds familiar to you. Maybe it's a hint of old community mental health, or bio-psycho-social holism, or some long ago discarded theorist. Or maybe it's just some personal idiosyncratic practice or belief that seems to fit into this model. Hugging is OK. Home visits are OK. Don't worry so much about diagnosis or boundaries. It's OK to self disclose and let people know you care. Gradually things get clearer for you: You've been practicing recovery all along, but calling it something else. Now there's a comforting thought. You can just change some words and some forms and maybe even the name on the door and go back to work. But, before you leave, Mr. advocate or reformer or whatever you are, could you please do something about the case loads and paper work and bureaucracies and billing and laws, as long as you're here anyway.

At that moment, you notice that I've gotten really angry. No, no, no!!! You're not already doing recovery. You don't understand. Recovery is about forming relationships with people, not just making diagnoses. It's about helping them rebuild their lives, not just treating symptoms. It's about working alongside someone, not doing treatment to them. It's about treating people like they're capable of self-direction and growth, not like incapacitated patients. It's about forming

real emotional relationships not artificial treatment relationships. It's about hope and empowerment, self-responsibility and respect, community integration and fighting stigma. Don't you get it? This is exciting stuff.

At that moment, I notice that you've gotten really angry. Just what am I accusing you of here? Not caring? Not respecting people? Not really helping them? If I can't see that you're doing the best you can with what you've got, I can just get lost. And don't forget about the case loads and paper work and bureaucracies and billing and laws on the way out.

A few holdouts remain. Some of that recovery stuff did sound pretty good, and we could use some new energy around here. Let's all calm down a little before we throw recovery out entirely. Is there some way we can build on what we are doing? Some next steps we can do? What's really different about recovery?

And I pause...

The real problem is that recovery is so big, when you actually see what it is. It changes your priorities, values, goals, relationships, and practices. Almost every decision is affected by recovery. Perhaps the best way to look at it is that recovery is a different culture. But cultures are hard to define because they are what we take for granted underneath everything. Culture is the things we just know without having to check. To transform into recovery we're going to have to check everything we know, not because it's all bad, but because that's what's needed to change a culture.

And looking out at the blank stares, I pause again...

Let me try again. I read somewhere that there are three models of change. The first one is development: You can take what you already know and do, build on your strong points, work on your weak points, maybe add a new technique or two. The development oriented people love it when I offer to do recovery based training. Can we especially get training for our psychiatrists? They're really a problem. The second one is transition: Let's see where you're at right now and where recovery would like you to be and make a plan to get from here to there. The transition oriented people love it when I create recovery based program inventories. Let's get a check list so we'll know what else we need to do. The third one is transformation: You create an internal upheaval and change something fundamental inside of you, and that change causes you to see things and do things differently. No one with an ounce of sense loves that model. So, of course it's the way I want to go.

Why? Because transformation was the path the Village took and it worked for us. I remember late one evening, probably a decade ago when the Medical Director of the hospital where we worked told me that he'd been watching the Village succeed with people no one else would have. He thought he'd finally figured out why: Because we respected our patients in a way no one else did. Several years later, two UCLA anthropologists spent a year at the Village to figure out what our magic was and why it seemed so hard to replicate the Village elsewhere. Their conclusion was that contrary to all the billing pressures, the administrative rules, and the professional guilds' standards, we were treating people like people instead of like patients. That

was it. It's probably not coincidental that the number one reason staff get fired at the Village, more than every other reason put together, is for not respecting our patients and not treating them like people. Our recovery culture is built upon our internal states, so things that are a struggle elsewhere seem to flow naturally for us.

As I look around, I see that I've driven off even more people sure they're being insulted yet again. I muse that it's going to take an awfully long time to achieve any transformation like this. Maybe I should have eased into this somehow and not driven away so many people. Maybe we shouldn't begin with transformation. Maybe we should begin with forming an ACT team, doing some home visits, hiring some consumer staff, learning how to do WRAP plans, building an employment and housing program. We could start by learning the notes; the music will come later. But even that's a lot to ask if people don't buy into the big picture first.

Only two sets of people are left in the room with me: People who are too young and idealistic to know any better, and people who have already experienced at least some of that internal upheaval and transformation and know in their heart I'm right.

If I'm going to draw you back in, I'll have to pull on your heart strings and the best way I know to do that is with stories. I have enough good stories of my own to rival the Arabian Nights, but for this task I'm going to need your stories. To begin with, I need two stories: First, I need the story of how your heart got you into mental health in the first place. I'm not talking about what school you went to or what classes you took. I'm talking about why you're in this strange and wonderful field instead of accounting or teaching or computer programming. There's lots of easier ways to earn a living than this. Was there some compelling emotional reason you're here? If so, remind yourself of it. Maybe you'll feel "too young and idealistic to know any better" again too. Maybe under those layers of hurt and disappointment, burnout and frustration, and learning how to get by, you can still be touched.

Then, I need a story of a time you let a patient get too emotionally close to you; where they got under your skin and healed you as much as you healed them; someone that, however it turned out, you have a strange feeling they were put in your life for some reason. Maybe you've "already experienced some of that internal upheaval and transformation" too.

Now you're ready for my bottom line. I believe that there are three levels of helping someone. The first one is the intellectual level. We can help people a great deal using our heads. We can do assessments, make diagnoses, and prescribe treatments. We can do case management, get people benefits, work on their quality of life, and give good advice in times of trouble. This is the level that our system usually works on.

The second one is the emotional level. We can connect emotionally, and become empathetic and compassionate. Our heart can go out to people and they can feel it. Then they'll know that we feel their pain, and that we really care about them, that we believe in them when they can't believe in themselves, and they'll feel healed even when we can't do anything practical. This, I believe, is the level where recovery occurs.

The third level is the spiritual level. Sometimes things happen that, depending on our spiritual views, seem miraculous, or like God is working through us. We tend not to mention these moments to each other. We don't usually have a shared language even to talk about them, let alone to try to help them happen more often. So they're rare special events and that's all they're likely ever to be for almost all of us.

I believe, that no matter how many recovery based practices we create, we won't really touch people until we change ourselves, and our system, to support staff to work openly on the emotional level. We'll need many things to accomplish this. We'll need to form teams to protect each other from being hurt and to avoid making ethical mistakes. We'll need to take care of each other emotionally. We'll need protection from liability. We'll need administrative support when we extend ourselves.

We'll also need to lower the walls that keep us emotionally apart from the people we're trying to help so we can touch them. Some of these walls are professional, some are personal, and some are administrative. Most of these walls are embedded in our present treatment culture, but not in the recovery culture.

Recovery says that the foundation of a good treatment is not a good diagnosis or even a good plan; it's a good relationship. For too long, we've deemphasized our relationship skills and expected them to come naturally. How good listeners are we really? Do we get a picture of what people's inner worlds are like so we can give them hope and motivation? How well do we engage with difficult people? Do they feel a caring connection with us? Do they trust us? How well do we negotiate and collaborate with people? Are they learning from their successes and their mistakes? Are they changing? Are we changing with them? How well do we help people take more self-responsibility without feeling abandoned? How well do we help people leave us and feel good about it? All of these skills are crucial to safely lowering walls and creating recovery.

Lowering walls is a frightening idea and will require a higher level of trust and of overall system health than most places have. We may have to do a lot of work as we go along in these areas if we are going to succeed.

When all is said and done, safely lowering the walls between us is what I think is really different about recovery, but it's not likely to be the first step. Where should we start?

## **We Treat Chronic Illnesses, Don't We?**

**By Mark Ragins, MD**

*(How dare I include in the title the politically incorrect “chronic illnesses”? Because this paper is not designed to reach out to politically correct recovery champions and consumer advocates. I've written plenty of other stuff for you. This paper is designed to engage our professional staff who, like me, were trained, in long, expensive, professional programs that taught us to help people by treating their illnesses. We're the people you turn to in an emergency, who shoulder the legal and clinical responsibilities in our system, who treat people who need it even if it means coercing them. A successful system, including a recovery based system, must include us. I'm “meeting them where they're at” and trying to bridge the gap between us so we can become collaborative coworkers.)*

When the various medical professions as we know them and the “medical model” emerged about a century ago the vast majority of patients had acute illnesses, mostly infections and injuries. The average life span was about 45 years. As we became more effective treating those illnesses the prestige of medicine grew and people started living long enough to get chronic illnesses. At the present time the vast majority of medical patients have chronic illnesses, but medical practice hasn't been transformed to meet patients' changing needs. Psychiatry, seeking similar prestige and funding levels, has increasingly sought to model our practice on the acute illness medical model used by our medical colleagues. Public psychiatry patients almost all have chronic illnesses, both because we target our efforts on people with serious, persistent mental illnesses and because there is so much stigma attached to mental illnesses that people rarely seek help until after they've been struggling on their own unsuccessfully for a long time. There are significant differences between how acute illnesses should be treated and how chronic illnesses should be treated that I will discuss in this paper. I believe that public psychiatry is not likely to meet our patients' needs more effectively while adhering to an acute illness model instead of a chronic illness model.

### ***Chronic illnesses differ from acute illnesses in several important ways:***

- 1) With acute illnesses it's reasonable to withdraw from life while being treated, whereas, with chronic illnesses the patient should try to maintain their “normal” life while being treated.
- 2) The ongoing symptoms of chronic illnesses often make it hard to maintain a “normal” life, necessitating rehabilitation to increase function, personal adaptations to cope, and community adaptation to maintain access to life.
- 3) Chronic illness more often than acute illnesses effect people's self identity.
- 4) Hope is more difficult to maintain for both patients and professionals with chronic illnesses because the symptoms resist treatment and helplessness settles in.
- 5) Recovery from acute illnesses usually results from symptom relief, whereas, recovery from chronic illnesses usually results from being able to maintain wellness and responsibility for self-

care and being able to replace professional supports with natural supports while rebuilding a meaningful life.

These differences have important treatment implications that have never been adequately addressed by our professions, our education, our helping roles, or our funding system. The premise of this paper is that if we seriously address the care of chronic illnesses we will arrive at almost all of the “recovery model” without ever really leaving the “medical model.”

***The treatment for most acute illnesses can be done to the patient, whereas, the treatment for most chronic illnesses must be collaborative.***

Patients with acute illnesses can literally turn their lives over to professionals to be treated, even living in a controlled hospital environment for awhile if needed, confident they will retake control over their lives once they are well again. All the patient is expected to do is “follow doctor’s orders.”

Treating patients with chronic illnesses the same way, whether they have asthma, diabetes, sickle cell anemia, AIDS, schizophrenia, or alcoholism is rarely successful. Long term “treatment compliance” is amazingly low with all chronic conditions. We simply can’t expect people to put their lives on hold indefinitely or stay living in hospitals for long periods waiting for treatment to work. They’ll choose to drop out of treatment rather than drop out of life. Acute hospitalizations tend to become “revolving door” because the condition continues long after the “stabilization” achieved in the hospital is long gone.

Instead, the patient must make chronic changes to impact their chronic illness while going on with their lives. The changes they need to make fall into two categories: Self-help and wellness. Self-help involves actively engaging in the treatment process, learning about your illness and how to deal with symptoms when they occur either on your own or with professional assistance. Wellness involves knowing what’s needed to prevent symptoms from occurring and how to keep symptoms from disturbing your overall sense of wellbeing and ability to go on with your life. Both include recognizing your warning signs, exacerbation signs, and crisis signs, knowing what to do about each, and having the self confidence and self responsibility to make the necessary decisions and take action.

Neither self-help nor wellness can be achieved by relying on a “follow doctor’s orders” model. A more empowering, collaborative model is needed.

***The treatment for chronic illnesses requires more teaching and usage of self help techniques than the treatment of acute illnesses.***

Teaching people about their condition and how to help themselves can take a lot of time, but if we don’t take the time to do it we’ll find ourselves taking care of them in the same situation over and over again (Think teaching to fish instead of giving a fish). We often find ourselves taking care of someone over and over again in the hospital without them really learning what changes they’ll have to make in their life to stop being hospitalized. Similarly, we work with people who stop taking their medications over and over again without really getting through to them to stay

on their pills. Without really realizing it, we're acting as if every hospitalization and every relapse is basically a new acute illness. We don't often help patients learn from their past.

Many people with chronic mental illnesses are not appealing students. Some were in special education classes or did poorly in school. Some have poor concentration or are irrational. Some are wrapped up in their own worlds, slowed down by depression, or confused by anxiety or mania. Some people even reported that people with schizophrenia have a "failure of historicity" meaning they can't learn from their pasts. One look at UCLA's skill training modules with their pervasive repetitiveness can give us some idea how hard teaching them can be. It's not impossible, but sometimes it's a lot of work.

The most overwhelming obstacle to teaching many people with chronic mental illnesses is that they "lack insight." They refuse to agree with us that they have an illness at all, so how can they learn about their illness and how to help themselves? There is a way around this blockage. Remember when they did the meta-studies of psychotherapy? It turned out that for a therapy to succeed, it didn't have to have the "right" explanation for the person's pathology. We could succeed with psychoanalytic explanations, behavioral explanations, interpersonal explanations, or a host of others so long as it was a "shared" explanation – one both therapist and client could agree to base their work on.

Our present dominant explanation, that a neurochemical imbalance causes most chronic mental illnesses, suffers from an impressive lack of "face validity" or "intuitive appeal." It just doesn't feel true to most people. It's a hard explanation for people to share with us. We can widen the number of people we can teach if we have at our disposal a wide array of plausible explanations we can choose between depending on which one our client is most likely to believe. After all, most people with chronic mental illnesses think something is wrong. They just don't think it's a neurochemical mental illness. Just like they're sure they're not crazy.

Would you be willing to teach someone that they're drowning in the same deep waters that Saints swim in and need to take medications and keep themselves grounded because they aren't prepared to use their spiritual gifts? Would you be willing to teach someone people to go on a "thought diet" like John Nash did in "A Beautiful Mind" to return to reality from the seductions of his unfettered thoughts? Would you be willing to teach someone to take medications and avoid using speed to strengthen his brain to fight off rays from a machine in outer space? Would you be willing to teach someone to create a "mother angel" to care for the "baby angels" whose cries have been keeping her awake for several years since her children were taken away from her? It makes for strange "informed consents," but I've used all of these "shared explanations" to teach people to take care of themselves who lacked insight.

Another problem with our prevailing neurochemical model is that it offers only limited opportunities for self help. Generally our advice boils down to, "Take your meds and avoid stress." That's barely hopeful and definitely not empowering or engaging.

We have been taught Cognitive Behavioral Therapy, that's proven for both depressive and psychotic conditions, and a variety of relaxation and anxiety reduction techniques, but in actual practice we don't use them much. We claim we're including them in our individualized

supportive therapy instead of using the “manualized” procedures because most of our chronically ill patients just don’t seem to be responsible enough for the “real thing” but, in reality, we’re far more likely to resort to problem solving, care taking, case management, structuring, and making decisions for people than teaching. The overt decision to individualize and include teaching within support is probably correct. The covert decision to abandon teaching probably isn’t correct.

There are a wide variety of other self-help techniques that have evolved out of the consumer movement (for example from the National Empowerment Center). Even though some of these like WRAP (Wellness Recovery Action Plans) have attained national prominence, virtually none of them have been included in professional curriculums or CEU conference trainings because of their non-professional origins. Many of these are more suited to our patients than the professionally created products and easier to use.

On the face of it, it would seem that all of this would require more motivation and participation from the patients, not less. It would seem easier to be dependent on professionals and cooperate with being taken care of than to learn to take care of yourself and work collaboratively with professionals. If we’re already having problems with compliance, why make things worse? Because one of the main reasons patients aren’t compliant is that the treatment doesn’t “work” in the way they expect it to work. They expect to be made well rapidly by the professionals and that doesn’t happen if they have a chronic illness. When that doesn’t happen they often withdraw. The expectations and the nature of the helping relationship need to change from the outset if we’re going to get more collaboration. The patients have to change models too.

***The treatment for chronic illnesses, unlike acute illnesses, requires actively engaging the person in their own treatment process.***

Attempting to engage people in the ways we’ve been taught, within the structures of our “auditor friendly” systems, who may be impaired by their mental illnesses and may not even believe they have a mental illness has been incredibly frustrating. The most common recommendation to address this problem unfortunately has been to recommend increased coercive powers to make people receive treatment whether they’re engaged or not. That might work for acute illnesses but not for chronic illnesses. Long term engagement is essential for people with chronic illnesses.

There are those who claim that forced treatment can achieve engagement by reducing symptoms and “restoring people to sanity” which will help people regain “insight” and then engage in treatment. While this may occasionally be true, far more often it leads to inadequate engagement and the “need” for further involuntary treatment.

The way out of this dilemma is to achieve engagement with people who are actively symptomatic and “unreachable.” A recovery based system approaches long term engagement very differently than our usual system. Many of their techniques are more effective than our usual ones. Here are some concrete examples:

- 1) Our system builds treatment on a good diagnosis. Our initial contact is normally an extensive assessment. (Common poor results of this approach are people avoiding us saying, “I don’t want

to have to tell my whole story all over again,” and an incredibly high rate of no shows for second appointments.) A recovery based system builds treatment on a good relationship. Their initial contact, which may be an “outreach” contact, normally focuses on welcoming and engagement incorporating charity, benefits assistance, sharing stories with peers to build hope, lowering boundaries by being “friendly,” finding shared interests and backgrounds, and building emotional connections through extended non-judgmental listening.

2) Our system builds expectations that people will have lower symptoms and feel well as a result of successful treatment. We normally assess symptom relief. (A common poor result of this approach is that people withdraw when they don’t feel better fast.) A recovery based system builds expectations that people will achieve goals they set and rebuild a meaningful life. They normally assess quality of life outcomes (like housing, employment, finances, avoiding legal problems, etc.) that can often be achieved when services are focused on them.

3) Our system hires licensed professionals and expects us to be able to connect with people within professional roles and boundaries thus avoiding any negative personal reactions we may have. (A common result of this approach is that people feel distanced, looked down on, and not really cared about; just part of doing our jobs.) A recovery based system hires lots of people with experiences with mental illnesses many of whom want to “give back” and asks them to use their past experiences to connect with people.

4) Our system tends to prescribe treatments based upon the illness being treated. (A common poor result of this approach is that people feel invisible, like “an interesting case” and disconnected from us.) A recovery based system tends to view treatment as supporting people on their very individual journey of recovery. It highly values their subjective experience of their illness and their search for meaning within a cultural context.

We can reasonably expect as a result of these changes to be asked to work without resorting to coercion with a variety of people we haven’t been well connected to before. Many of them won’t meet our usual criteria for collaborative treatment. They may not believe they have a mental illness. They may abuse drugs. They may not be responsible, missing appointments, not take medications “as ordered,” and not be able to give informed consent. It’s not that we haven’t tried working with some of these people before. It’s that we haven’t been very successful. The recovery model expects us to succeed now. The pressure here is that, unlike in the past when we could blame the patient or the insufficient involuntary treatment laws, now we’ll be held accountable for helping people we may regard as untreatable. An escape hatch is closing.

We’ll be asked to be more flexible and less authoritarian than ever before, more willing to work collaboratively with our patients, more willing to take risks with people working outside the norms and protections of standard medical care, and more willing to rely on nonprofessional and mentally ill colleagues.

***The treatment for chronic illnesses requires including its effects on the person's ability to live successfully.***

There's an old study that determined that the correlation between schizophrenia and poverty wasn't due to poverty causing schizophrenia. It was due to schizophrenia causing poverty. They documented that people with chronic mental illnesses tend to experience "downward social drift." Their reasonable conclusion was that the symptoms of mental illness get in the way of making money. We can argue that it's not really the symptoms themselves that are so destructive, but actually stigma, segregation and loss of opportunity, civil rights reductions, treatment effects, institutionalization, etc., but basically we'd all agree that having a chronic mental illness is likely to hinder your life. We just don't like dealing with that reality.

Psychiatrists, psychologists, and nurses tend to push off life problems on social workers. Social workers tend to push them off on case workers and community workers. The entire mental health field tends to push them off on other social service agencies. We all want to stay focused on treating the illnesses themselves. Unfortunately, that just doesn't work very well. Most of our patients with chronic mental illnesses still lead impoverished, heavily restricted lives.

Why should we believe that we could do better if we got more involved? After all, we didn't learn much about housing, employment, education, finances, avoiding jail, or family preservation in school. Because "supported services" (like supported housing, supported employment, supported education) actually work when they're integrated into mental health services. Some are even proven "evidence based practices." It turns out, for example, if a supported employment worker is added to an ACT team many more clients get employed than if they're referred to the local Department of Vocational Rehabilitation. Why? Some would claim it's just a matter of reducing interdepartmental red tape and improving access, but I don't think that gives us enough credit. I think that if we focus on employment we're able to use our understanding of people's illnesses and treatment effects to design effective individualized support plans and I think that if we focus on using our ongoing treatment relationships with people we can help motivate them to implement these plans.

There's a lot of variation in what supports people need and how to motivate them to move forwards. Someone whose concentration is affected by intrusive voices is different from someone who uses marijuana regularly. Someone whose moods are unstable because of manic-depression is different from someone with a borderline personality disorder. Someone who's slowed down from a major depression is different from someone who's on high dosages of sedating medications. Our expertise can help us move from "placement" and generic "training" to more effective individualized supported plans.

***The treatment for chronic illnesses often requires including rehabilitation and personal adaptation.***

Most of our positive experience with rehabilitation and personal adaptation is, strangely enough, with acute illnesses. For example, many of us have personally experienced dramatic positive effects from a time limited course of physical and/or occupational therapy and a set of crutches helping us to recover from a broken leg. Our experiences of the effectiveness of rehabilitation

with chronic illnesses, like muscular dystrophy or chronic heart failure tend to be less compelling.

Perhaps our best outside source of inspiration for effective rehabilitation with chronic illnesses could be special education for learning disabilities: Before special education was mandated, it was routine to consider many children “retarded,” not bother to understand them too carefully, segregate them away from normal children, give up on them as “unteachable,” and take care of them indefinitely. Despite numerous confounding administrative, legal, and fiscal issues, we’ve made substantial progress since then including Individualized Education Plans based on multidisciplinary assessments, “mainstreaming” them into normal classrooms with extra support, and including social and employment skills training to help them become productive adults.

But we don’t really have to look outside mental health for inspiration. There are striking examples of successful rehabilitation within our own fields ranging from UCLA’s early work with “unteachable” patients at Camarillo State Hospital, to Boston University’s inclusion of people with serious mental illnesses in the normal college population using a “chase, get, keep” support model, to Fountain House and numerous other clubhouses helping people who were stuck in patient roles to succeed in a variety of other meaningful roles.

I only really embraced rehabilitation and personal adaptations for chronic mental illnesses (like a Walkman to block out the voices or crocheting a blanket to cope with chronic insomnia or getting a dog to help go outside despite agoraphobia) when I changed my focus from treating illnesses to helping people with chronic illnesses have better lives. We’re not using rehabilitation like the Orthopedists are to help broken legs heal faster. We’re using rehabilitation like the special education people are to help build lives. If you can shift focus from treating illnesses to rebuilding lives – and this is the most important shift that the recovery model requires of us – than you’ll value and learn to use rehabilitation and personal adaptation techniques.

***Chronic illnesses affect people’s self-identity more than acute illnesses do.***

Very few people become “influenzics” but many people become “epileptics” or “asthmatics” or “schizophrenics.” It takes a chronic illness to internalize truly destructive identities like “cripple” or “retard” or “loony” or “stoner.” A good doctor treating a patient with a chronic illness over the course of many years is likely to become increasingly personal over the years. He remembers your name and not just the medical details of your case. He’s likely to talk about how your life is as much as how your illness is. He gets to know your family. This has the effect of stopping the illness from swallowing you up. The message is, “You may have to come see me because of your illness forever, but that doesn’t mean that’s all there is to your life.” The illness doesn’t have to define who you are even with the professionals treating you. They can relate to you in a friendly way instead of a strictly professional way.

Mental illnesses and substance abuse disorders have a particularly virulent ability to rapidly destroy our self-identity and our public-identity. Even a short live postpartum depression, for example, where a mother had thoughts of killing her infant, is likely to permanently and profoundly alter her view of herself as a good mother. If she tells someone else about her symptoms they’re likely to call DCS and have her child taken away entirely. Even one drug

conviction for an adolescent can make them ineligible for federal financial aid to go to college and make them feel like a social reject. Mental illnesses and substance abuse disorders are strikingly “crippling.”

We have quite a number of people for whom even if we gave them a medication or a therapy that made all their symptoms disappear, they would still remain on our caseloads crippled for life. In fact, there are many people for whom we’ve already given them a medication or therapy that made all their symptoms disappear on our caseloads now.

By contrast, Moral Treatment institutions in the 1800s had striking recovery rates. About two thirds of psychotic people admitted to these small, compassionate, God-faring institutions were discharged back home recovered within 6 months. We can’t even really imagine results like that with our present treatment programs. Why are things so different now? I think mostly because even when we’ve “stabilized” people they’re not really well again; they’re still crippled. The illness (including both positive – like financial benefits - and negative effects) has become an ingrained part of who they are.

Moral Treatment didn’t focus on treating illnesses. Most of the staff weren’t even professionals. They focused on helping you feel whole again, on helping lost souls find their way back to God again, on building you up so you could make a contribution again. Some would argue that this is a good treatment for mental illnesses, but that’s not my point. My point is that when the symptoms go down for whatever reason recovery results much more often if you’re self-identity has recovered instead of been crippled. (Many recovered people, like John Nash, report that their symptoms aren’t gone. They’re just easier to ignore, not so urgent, easier to detach from.)

It’s important not to focus on the self-identity effects only after acute treatment has achieved stabilization and the underlying crippling has emerged. We must focus on it throughout our treatment process (even when they’re tied down, yelling in the ER, yet still able to remember how we treated them). There are too many ways in which we inadvertently contribute to their crippling throughout our treatment process. I’ve met many people who say they were devastated when a hospital staff told them they had schizophrenia and would never recover and would have to either live with their parents or in a Board and Care forever. Others have never tried to return to work even when they felt better because their old psychiatrist told them they were permanently disabled, work would be too stressful for them and cause a relapse, and because they didn’t want to risk their Social Security benefits. The effects of being tied down, mostly naked with cameras watching you, or being called a “dirt bag” in detox, or being told, “Why don’t you just get it over with and really kill yourself next time?” can be lifelong.

We need to incorporate a secularized version of Moral Treatment into our daily practice. Some of this will be accomplished by including paraprofessionals who are particularly compassionate, accepting, and hopeful in our treatment teams. Some of this will be accomplished by consumer advocates and “language police” harassing us to change our stigmatizing and traumatizing habits. Some of it will be accomplished by us becoming more personal and friendly, lowering the professional walls, remembering their names, asking about their lives and not just their illnesses, and getting to know their families.

*It all comes back to hope.*

The reason the phrase “chronic mental illness” is considered politically incorrect is because it carries the implication of hopelessness (and therefore was replaced by “persistent mental illness” which can be persistently fought). The words, “There’s nothing more I can do for you” can’t be far behind. Indeed about half of all clients in our clinics receive “meds only” – brief doctor visits every month or two for unending refills.

We become very defensive when confronted with our pervasive hopelessness and begin looking around for someone else to blame: It’s the underfunded system’s fault. It’s the paperwork and MediCal. It’s incompetent, senseless, or out of touch administrators. It’s restrictive involuntary treatment laws. It’s “low functioning” patients, unresponsive illnesses, ongoing substance abuse. It’s low quality psychiatrists or lazy county staff who don’t really care about people. It’s codependent, sabotaging, exploitative, or crazy making families. The list goes on and on as we descend into a maelstrom of frustration.

I’m casting blame in another direction, on our acute illness model. If successful recovery is symptom relief and cure and treatment is limited to what we can do to compliant patients we’re likely to become frustrated and hopeless. If, instead, we use a chronic illness model other versions of recovery emerge (including self responsibility, wellness, and rebuilding function, roles, and a meaningful life) and other treatment approaches emerge (including engaging through shared explanations, teaching self help, rehabilitation and personal adaptations, and restoring self-identity) and we’re likely to become less frustrated and hopeless. The recovery based system transformation gives us the opportunity (and in California some funding) to incorporate these approaches.

Rachel Remen writes movingly of her experiences as a doctor in the book “Kitchen Table Wisdom.” She followed in the footsteps of numerous other family members into medicine, but she turned out differently because she has struggled with severe Crohn’s disease since her teens, a recurrent inflammatory bowel illness that caused her recurrent diarrhea and required numerous surgeries to treat. She says she became a “wounded healer” and has gone on to work with people with chronic and terminal illnesses to help them find meaning and with burnt out doctors to help them find meaning.

She tells one story of a man she was working with who had cancer and was receiving chemotherapy. Every week he would come into the clinic and sit talking with his oncologist for twenty minutes while the chemotherapy flowed into his vein. After awhile it became clear that his cancer was not going to respond to the chemotherapy and his doctor told him he didn’t need to keep coming in any more. The patient asked if he could keep seeing the doctor anyway, but the doctor told him that there was no point. There was nothing more he could do for him. The patient felt such a loss he would’ve been willing to have continued to take highly toxic, ineffective chemotherapy just to spend time with his doctor. As chance would have it, the oncologist was also working with her because he felt he didn’t have anything to offer his incurable patients. He never realized the impact he was having on their lives.

An acute illness model tends to blind us to many ways of helping people, and it tends to hinder us from finding meaning.

The recovery movement has grown rapidly (and resisted efforts to change its name) because recovery is hopeful. Many people – patients, families, even staff – are desperately thirsty for hope. Unfortunately, most professionals don't feel the hopeful about recovery. We equate recovery with cure and most of our patients have incurable illnesses. We consider the entire recovery movement to be unrealistic, naïve, or even manipulative. Recovery with chronic illnesses is not dependent on cure. Patients can recover from a heart attack without their cardiac muscle regrowing. Patients can recover from a stroke without their neurons regrowing. And patients can recover from schizophrenia without their neurochemicals regaining balance. They recover when their lives are rebuilt not when their illnesses are cured. We can help them rebuild. There's hope after all.

There's a catch to all this: Illnesses don't recover, people do. We can directly cure illnesses, but we can't directly "recover" people. They have to be the center of their own recoveries. We can help give them hope, empower them, promote self responsibility, and create opportunities for meaningful roles, but they have to do the actual work of rebuilding. That's why the recovery model is "consumer centered" and "consumer driven." They have the starring roles. We're the supporting cast.

## **Person Centered vs. Illness Centered**

By Mark Ragins, MD

I've been doing a lot of workshops lately trying to help people really "get" recovery. I'm beginning to think that a crucial step to open up a clear vision of recovery is to move from an illness centered perspective to a person centered perspective.

Let me try to explain with an analogy: Before Copernicus came along we believed that the earth was at the center of the universe and that everything else moved around it. Although this made sense to everyone, it did make it difficult to describe the orbits of the other planets, the sun, and the stars as we observed them moving around the earth in complex, idiosyncratic paths. Copernicus figured out that although the earth is a very important place, it isn't actually the center of the universe or even our solar system. The earth is one of a number of planets that revolve around the sun. It turned out the orbits were simple ellipses explainable by gravity.

Our mental health system at present is almost entirely illness centered. We act as though we believe that illnesses are at the center of the universe and that everything revolves around them. We need a great deal of complex, idiosyncratic explanations to make sense of people's lives from this perspective: Housing is in treatment settings, friends are social support networks to reduce the risk of relapse, employment is therapeutic activity, and families are given psychoeducation so they can be extensions of treatment professionals. If we drive someone to a job interview we write a MediCal note stating that we did in vivo anxiety reduction and social skills training for a schizophrenic who has barriers of paranoia and interpersonal anxiety in order to get him some employment as a therapeutic activity in order to decrease his symptoms and reduce the risk of hospitalization. That all may be true but it's a pretty convoluted, pre-Copernican orbit.

We can change our perspective. We can figure out that although illnesses are very important, they aren't actually at the center of life. People are. It turns out that the orbits are relatively simple from this person centered perspective. People live in homes; they have friends, jobs, families, and illnesses. When we drive someone to a job interview, we're trying to help them get a job.

Our illness-centered perspective pervades everything we do. For example, when someone first comes to us in need of help with their problems, the first thing we do is to define their problems as symptoms of an Axis I Major Mental Illness. If we can't do this, they're not eligible for services. We can't get paid. They have to go away even if there's no other help available. If we can identify their illness, but they can't, they are lacking insight and we need to assess them for dangerousness, suicidality and grave disability. If they have any of those things, we can lock them up. If not, there's nothing we can do. We rarely shift to a person centered perspective to find other ways to be helpful.

If we both agree they have an illness, we can try to help them within our illness centered perspective. We can give them treatment for their illness, and if we can relieve all their symptoms, they shouldn't have any more problems, since their problems were all symptoms in

the first place. If, as is far more common, we are unable to relieve their symptoms, even with multiple medications and lengthy therapy, we can get them other social support services as long as we can use their ongoing illness to justify their needs. Labeled with the correct diagnosis, they can get Social Security income, Shelter Plus housing subsidies, vocational rehabilitation, disabled students' support, etc.

When someone first gets a serious illness, it can feel like it swallows them up. It's hard to hold on to their remaining strengths and keep hope alive. Our illness centered responses, in effect, agree with this alarming feeling. We can clearly see that the illness has indeed swallowed them up. We took a careful history of their illness that documented it. They are now officially a schizophrenic or a manic depressive. But they shouldn't lose hope just because we don't see their strengths either. They've come to the right place. We'll be the strong ones for them now. Hope rapidly becomes entirely coupled to our ability to successfully treat their illnesses. They can try to keep hoping we'll be able to cure them and that then they'll be fine again. Unfortunately, along the way we may neglect and lose all the other things that used to give them hope before they became patients like family, loved ones, their own strengths, God, perseverance, resilience, pets, understanding, compassion, or love. With illnesses at the center of life instead of people, treatment is the only visible wellspring of hope.

I was taught in medical school the distinctly illness centered idea that the foundation of a good treatment is a good diagnosis. I no longer agree. It seems to me that the foundation of a good treatment is a good relationship with the person – a distinctly person centered idea. Think about it. If I have a good diagnosis, but no relationship, it's not really very likely that much will happen. On the other hand, if I have a good relationship, but the wrong diagnosis, I'll eventually figure it out and get it right. More to the point, they might trust me enough to tell me the truth about their illiteracy, sexual molestation, drug abuse, lack of medication taking, abusive spouse, or whatever it was that they were hiding that confused me in the first place. (Of course if I was firmly illness centered enough, I wouldn't see any problem as a lack of relationship. Instead I'd see, as a recent analyst of the CATIE drug study did, that "patient-initiated drug discontinuation appears to be a core illness behavior from schizophrenia onset to chronic illness.")

The reason it's important to change from an illness centered perspective to a person centered perspective to "get" recovery is because illnesses don't recover, people do. Illnesses can be cured, put into remission, stabilized, or controlled, but they don't recover. The person with the illness recovers when they rebuild their lives from the destruction caused by the illness. There's no need for recovery if there's no destruction from the illness. Illness centered treatment is sufficient. Unfortunately, most people with serious mental illnesses do have destruction in their lives and need person centered recovery services. The process of recovery is the same whether they're recovering from an illness or from any other serious destruction, like a rape or the death of a loved one, or the trauma of an abusive childhood, the lack of a family, or going to war. People can recover functions--as in the ability to read, to sleep restfully, to work, to have coherent conversations, to make love, to raise children, to drive a car, etc. People can recover external things – as in an apartment, a job, friends, playing in a band, a spouse, a car, family relationships, stereo, TV, educational programs, etc. And people can recover internal states – as in feeling good about oneself, satisfaction, self confidence, spiritual peace, self-identity other than mentally ill, self-responsibility, etc. But when all is said and done, it still remains that

illnesses don't recover, people do. That's why we can't even see recovery from an illness centered perspective. It simply doesn't exist. We must switch to a person centered perspective for recovery to emerge.

Here's an example. Imagine a spectacular football player. He runs with amazing grace and abandon. He cuts sharply. He's fearless. He finds the holes seemingly by instinct. And now imagine that a hard tackle twists his knee and severely injures it. But he gets great medical care. His arthroscopic surgery is a success. He's very motivated so he does months of strenuous rehabilitation, and as a result his knee is completely healed. Tests show that it's just as strong and flexible and mobile as ever. But, when he gets back on the field somehow he's never the same. He doesn't move the same way. He's been changed by the injury. Even though he's no longer injured, he's still subtly crippled. More treatment simply won't help, unless we switch to a person centered approach. We have a large number of people with serious mental illnesses who, even if we gave them pills tomorrow that relieved all their symptoms would still be severely "crippled." As a matter of fact, we have lots of people who we've already given them those pills who are still on our caseloads crippled. And we keep giving them more illness centered treatment.

Don't misunderstand me. I'm not against treating illnesses. It's much easier to avoid being crippled if there's effective treatment and rehabilitation. But I am against waiting to begin person centered recovery services until after the illness centered treatments are successful. Recovery should be our principal concern from the beginning. After all, isn't that football player thinking about how he's going to return to the field from the moment he's injured? "Meeting people where they're at" usually means beginning with recovery.

By contrast, the beginnings of public mental health treatment are usually far removed from recovery. I've heard that half of all people in the public mental health system enter involuntarily. These people are forcibly restrained by police or ambulance personnel and brought to crowded, frightening psychiatric emergency rooms, and rapidly sedated often with forced injections "losing" their mind still further. Too often, we're inadvertently adding more trauma and destruction to be coped with later and dramatically reducing their sense of hopefulness, self confidence, collaboration, and self determination--the keys to their recovery. Even if people begin voluntarily in a clinic, they're likely to have to begin with long waits and extensive intake processing that focuses on system needs and diagnostic based treatment plans that may be experienced as impersonal processing that does not really respond to their needs. Most don't return.

Here's my view of person centered recovery based services from beginning to end: The first priority is to establish a relationship. If people don't return, even the best assessment and treatment plan is a waste of time and paper. We should have a variety of outreach and engagement offerings to welcome people, whether they come voluntarily or involuntarily, that precede assessment. These offerings should be based on helping to meet the person's goals directly. For example we might help by actually listening to make someone feel better. We might help them straighten things out with their family or boyfriend. We might give them instructions how to get a two week hotel voucher from the welfare office, or advocate for them to get their SSI check restarted. We might call family to get money sent for a ticket home. We

might give them a cigarette and a quiet place to think. We might give them a lunch or a day labor job to make \$20. Or we might even give them an explanation for what is wrong with them so they're less confused and more hopeful. After we've been helpful, perhaps a number of times, the person may be engaged enough with us to form a collaborative service relationship.

The goal of our service is not to treat illnesses, but to help people with serious mental illnesses have better lives. For example, when we give someone medication it's not to reduce voices; it's to help them get a girlfriend or keep their job. We focus not on illness based outcomes, like symptom relief, but on quality of life outcomes, like improved housing, employment, education, finances, health care, social life, and families, while avoiding legal problems, drug abuse problems, hospitalization, and homelessness. The goals are socially valued, but individually determined, based on each person's choices. Services, including, but not limited to, treatment and rehabilitation, are goal driven, not symptom driven.

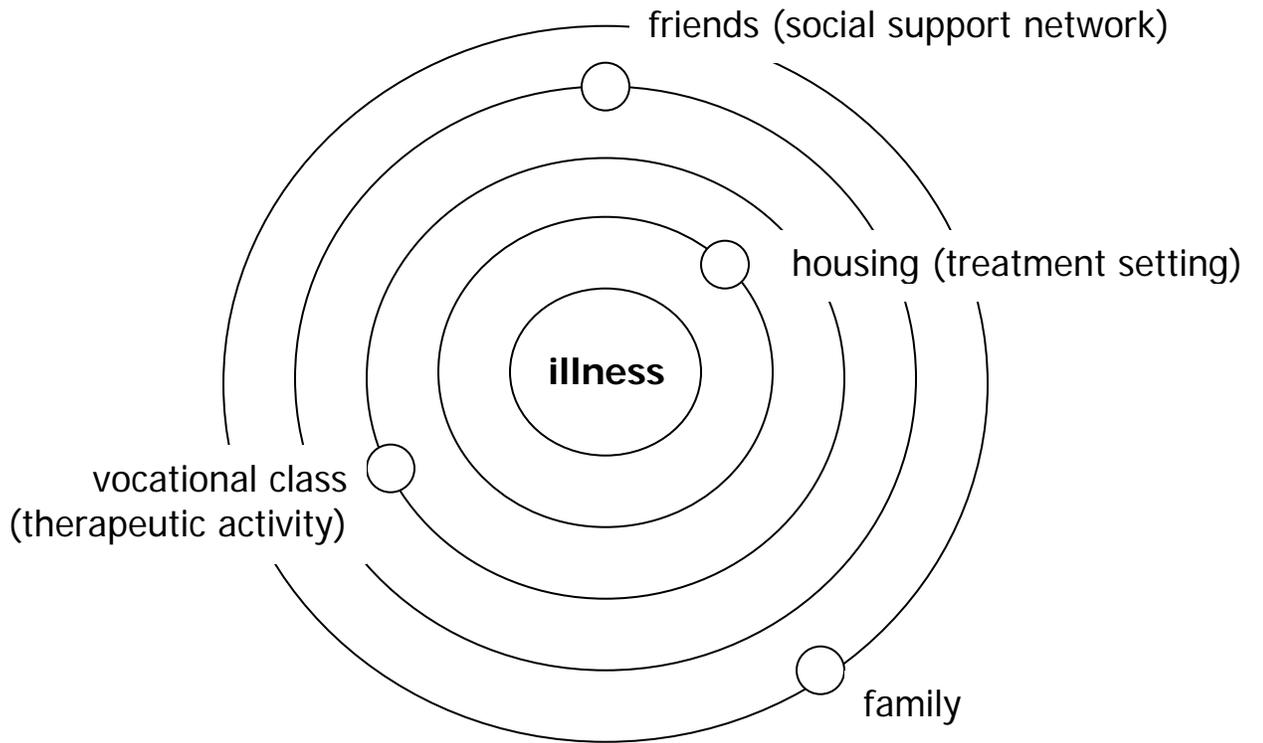
Throughout, a focus on the relationship is primary. SAMSHA's new recovery consensus statement includes following the person's self direction, being empowering, strengths based, respectful, responsibility building, and hopeful. These are all characteristics of service relationships that build recovery. Sometimes we'll give up ground on the illness treatment or rehabilitation if it means gaining ground on the person moving towards a recovery relationship with us.

The goal throughout is to help the person attain recovery. We guide them through the process of building hope, empowerment, self-responsibility and attaining meaningful roles in life. We don't leave recovery to chance, hoping that it will result from our treatment and rehabilitation efforts. We intentionally use treatment and rehabilitation as tools to promote recovery. We choose techniques that emphasize growth, building skills and natural supports, learning from successes and failures, and internalizing recovery gains to enhance resilience and wellness, rather than emphasizing stability, caretaking, risk reduction, and treatment compliance. Recovery is inside of them, not us.

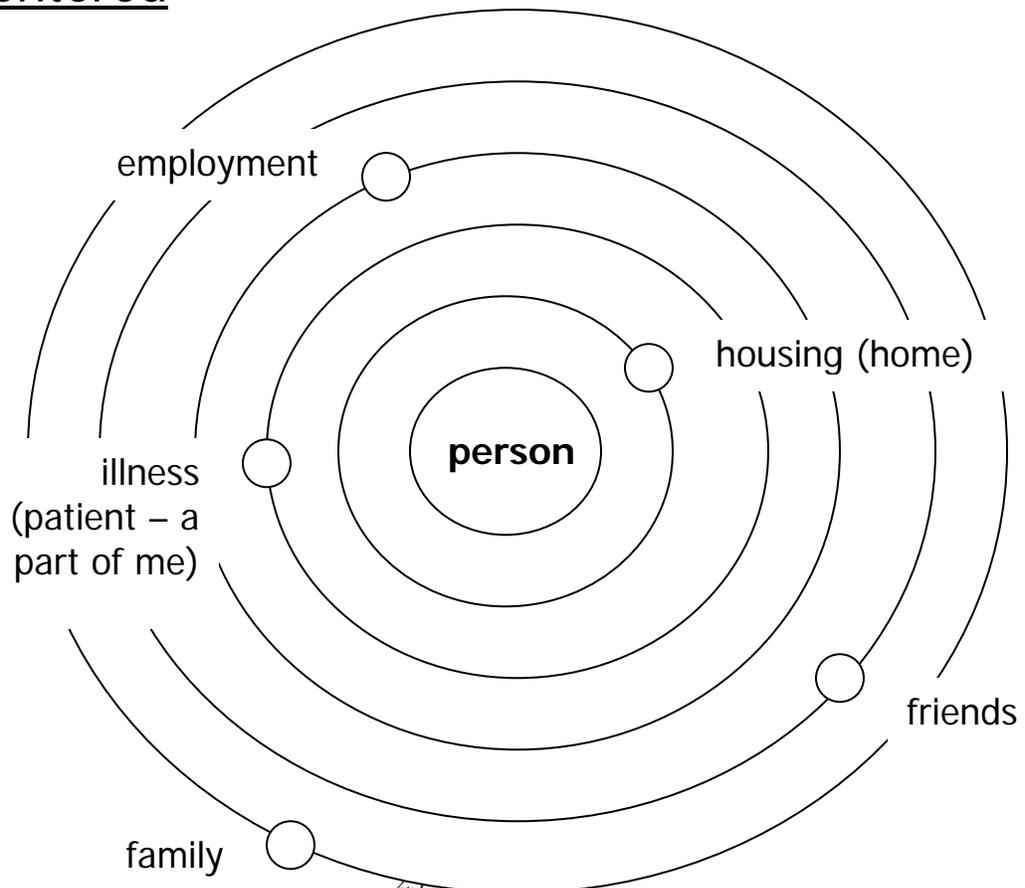
All recovery based services are transitional, though usually not time limited. The person moves on as they grow and change, not as their illness responds to treatment. They graduate and leave the system, when they are able to manage their lives, including their illness if it's still there, not when they are cured.

When all is said and done, the recovery process and what we need to do to promote it is much clearer from a person centered perspective than from an illness centered perspective.

illness centered



person centered



<b>PERSON CENTERED</b>	<b>ILLNESS CENTERED</b>
The relationship is the foundation	The diagnosis is the foundation
Begin with welcoming – outreach and engagement	Begin with illness assessment
Services are based on personal suffering and help needed	Services are based on diagnosis and treatment needed
Services work towards quality of life goals	Services work towards illness reduction goals
Treatment and rehabilitation are goal driven	Treatment is symptom driven and rehabilitation is disability driven
Personal recovery is central from beginning to end	Recovery from the illness sometimes results after the illness and then the disability are taken care of
Track personal progress towards recovery	Track illness progress towards symptom reduction and cure
Use techniques that promote personal growth and self responsibility	Use techniques that promote illness control and reduction of risk of damage from the illness
Services end when the person manages their own life and attains meaningful roles	Services end when the illness is cured
The relationship may change and grow throughout and continue even after services end	The relationship only exists to treat the illness and must be carefully restricted throughout keeping it professional

# **Principles of a Recovery Based Service System**

By Mark Ragins, MD

Our present system, built on treatments that are focused on symptom relief and treating illnesses, sometimes results in recovery as a byproduct.

In contrast, a recovery based system has recovery as its primary focus and goal. The recovery process itself is the foundation upon which services are built. Many current services (for example, medications, therapy, rehabilitation, psychoeducation, and case management) can be adapted to become strong supporters of recovery. Other services (for example, coercion, sedation, caretaking, and segregation) need to be seriously limited to avoid inhibiting recovery. And another new set of services (for example, outreach, empowerment, self-management, advocacy, and graduation) can be developed and added to our efforts to promote recovery. Our service choices, whether to adapt, limit, or add, need to be grounded in recovery based service principles.

We can create a clear set of service principles based upon the characteristics of the recovery process itself. These principles form the foundation on which we build a recovery based service system.

## **Recovery Characteristics**

- 1) Recovery is a process the person goes through, not the illness
- 2) Recovery is a growth Process
- 3) Recovery is a highly individualistic process.

## **Service Principles**

- 1) Our relationship with the person is more important than our relationship with their illness: We must prioritize engagement over diagnosis, personal trust and collaboration over illness treatment.
- 2) Staff must believe in and promote growth and recovery: Goals must be growth oriented rather than stability oriented. Services must be transitional in design, promoting positive flow. Services must include rehabilitative skill building.
- 3) Services must be highly individualized: people's needs must dictate our service offerings rather than our service offerings dictating their needs.

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|--|---|
| <p>4) Recovery depends on internal, subjective changes within the person.</p>  | <p>4) Staff must believe in people's ability to make their own decisions, promoting self-determination and choice rather than telling people what to do. We must be aware of each person's internal process, solicit goals in their own words, teach them about their opportunities, and assist them in making their own choices.</p> |
| <p>5) Recovery is a developmental process, proceeding flexibly through predictable stages: Hope, empowerment, self-responsibility, and attaining meaningful roles.</p>   | <p>5) Our services, relationships, and culture must focus on building hope, empowerment, self-responsibility, and attaining meaningful roles.</p>   |
| <p>6) Recovery depends on belonging within our community to attain meaningful roles.</p>   | <p>6) Our services must extend into the community. We must both help people be better able to get along in our community and help our community be a better place for them to get along in. We must advocate for and create opportunities in other social service agencies and other community activities.</p>                        |
| <p>7) Recovery results in positive, observable changes in people usually including decreased endangerment, increased engagement with their own recovery, increased goal setting and attainment, increased skills and supports, and improved quality of life.</p> | <p>7) Programs can indirectly document the highly individualistic, subjective process of recovery by objectively tracking these positive results and must be held accountable for successfully promoting them.</p>  |

As we seek to implement these principles, the question is not whether we are working by these principles at present, or even if we think we can achieve them in the face of numerous barriers, but whether these are principles we can all agree to aspire to and work towards. If we can, then we have a recovery based foundation for our transformation efforts.

## Milestones of Recovery Scale (MORS)

Dave Pilon, Ph.D. and Mark Ragins, M.D.

### Background and Introduction

Over the last decade, the concept of recovery has become nearly universal in public mental health policy discussions. For example, the following statement appears in the recently enacted Mental Health Services Act (MHSA) in California:

“Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers...”(Mental Health Services Act, Section 7)

This new focus on recovery has significant implications not only on the types of mental health services offered and the manner in which they are delivered, but also on the way in which we evaluate the effectiveness (outcomes) of our mental health programs and systems. For example, ten years ago, McGlynn (1996) described five major domains of outcome measurement for mental health programs:

1. *Clinical status* refers to how a disorder is defined, particularly in terms of the presence and severity of symptoms.
2. *Functional status* refers to the ability of an individual to perform age appropriate activities.
3. *Quality of life* measures have the “objective to bring the client perspective into outcome measurement.” They measure “the importance of different decrements in functioning on an individual’s perception of his or her quality of life.”
4. *Adverse events* refer to negative outcomes (e.g., hospitalization, mortality, incarceration) that result from system problems that could be avoided with appropriate care.
5. *Satisfaction with care* refers to the consumer’s perception of the quality of the care that she or he received.

While some would suggest that this list is comprised of many of the components of recovery, the concept of overall recovery from a disabling mental illness as a domain of outcome measurement is nowhere to be found. Contrast this with the recent statement by Substance Abuse and Mental Health Services Administration (SAMHSA) Director Charles Curie when his agency issued a consensus statement on the features of recovery:

“Recovery must be the common, recognized outcome of the services we support. This consensus statement on mental health recovery provides essential guidance that helps us move towards operationalizing recovery from a public policy and public financing standpoint. Individuals, families, communities, providers, organizations, and systems can use these principles to build resilience and facilitate recovery.” (February 16, 2006)

This statement demonstrates that recovery has indeed become the new benchmark for evaluating mental health program effectiveness. However, even with such consensus statements, it remains remarkably difficult to define what is meant by the concept and even more difficult to agree on how to measure it. The features of recovery generally have not been formulated in a sufficiently coherent and measurable framework that would allow the systematic evaluation of the effectiveness of a particular mental health program or system in helping its consumers to recover.

We believe that much of the difficulty in defining and measuring recovery arises from the fact that the most “personally meaningful” characteristics of recovery are the internal subjective cognitive and emotional states of the person experiencing it. For example, many consumers speak of “feeling more hopeful,” “becoming more empowered,” and “deciding to take more responsibility for myself” as they recover. One approach to measuring recovery, then, would be to measure these internal cognitive/emotional states of hope, empowerment, and responsibility (or other similar states). Theoretically, it should be possible to measure a consumer’s status on these dimensions at admission to a mental health program and then measure repeatedly as the consumer goes through the program and finally when the consumer is discharged. If the program is effective, the consumer should experience greater levels of hope, empowerment, and self-responsibility at discharge than she did at admission.

However, there are several problems that arise from such an approach. First, it is extremely difficult to reliably measure these sorts of internal subjective states. Because these are subjective experiences, it is extremely difficult for two outside observers (raters) to agree on an individual’s level of hopefulness or sense of empowerment. Second, this problem is only partially solved by having consumers rate themselves on these dimensions because it is unclear to what extent reports of feelings of hopefulness or empowerment are influenced by relatively stable character traits regardless of outside “interventions” and life improvements. We all know individuals who are perpetually hopeful (or hopeless) almost regardless of the objective situation in which they find themselves. Third, even if we are convinced that we can induce meaningful changes in our clients’ levels of hopefulness and/or empowerment through our clinical interventions, does it make sense to evaluate our effectiveness on this basis rather than on life improvements? We would argue that greater subjective feelings of hope and/or empowerment come about as a result of significant changes in the life circumstances of the individual (e.g., becoming housed after being homeless, making one’s own decisions after being on conservatorship, getting a job after being unemployed) at least as often as the other way around. In evaluating program effectiveness, it seems to us to make more sense to hold programs and systems accountable for their ability to help their consumers to make these kinds of significant changes in their lives. Finally, we would also argue that when it comes to demonstrating our effectiveness to the public and to our funding sources, it is much easier to justify continued funding for our programs when we can show meaningful changes in the objective circumstances of the lives of the consumers we serve (e.g., more jobs, fewer hospitalizations and incarcerations, less homelessness) than in their internal subjective cognitive/emotional states.

Based on these considerations, we suggest that, *for the purpose of evaluating the effectiveness of mental health programs and systems in promoting recovery, we should measure the*

*objective and easily observable behavioral correlates (“milestones”) of recovery* rather than the subjective internal experience of individuals experiencing recovery. Our challenge then becomes to identify a set of observable correlates that actually correspond to the experience of recovery.

Our own approach to operationalizing and measuring recovery began in the Spring of 1997, under the leadership of Paul Sherman and Betty Dahlquist. The California Association of Social Rehabilitation Agencies (CASRA) sponsored several meetings including administrators, clinicians, consumers, and advocates to try to create tools for mental health managed care to divide consumers into service need groups and measure their outcomes from a rehabilitation/recovery point of view. Tools for this purpose already existed based on clinical acuity or level of care or cost of care, but none of these tools were recovery based. The objective of the workgroup was to create a system by which mental health providers could be held accountable for the outcomes of the services they provided to the different subgroups of consumers that were identified. Although it was not our original intention, we created a scale that describes what we believe are the most important objective and measurable correlates of the process generally referred to as “recovery.” This paper describes the process by which this “Milestones of Recovery Scale” (MORS) came about, some of the development work that has taken place with it since, and some possibilities on how it might be used in the future.

### **Properties of the Milestones of Recovery Scale**

So what are “the objective and easily observable behavioral correlates of recovery?” It should be pointed out that the underlying dimensions of the Milestones of Recovery Scale were arrived at “empirically” (experientially) rather than theoretically. By that we mean, the CASRA workgroup participants were given the task of assigning the population of all individuals with a severe and persistent mental illnesses into groups that would reflect the commonalities and characteristics of the consumers in that particular group. Some of the dimensions that were considered in creating the groups were items such as level of symptom distress, willingness to take medication, existence of co-occurring disorders (e.g., substance abuse), extent of social support network, level of danger to self or others, employment status, frequency of crisis incidents, engagement with the mental health system, and extent of meaningful roles in the community, just to name a few. Workgroup participants were also allowed to add their own dimensions with the single restriction that they could not differentiate groups based on the level or type of service they thought the consumer should receive. The aim was to create a classification system based on consumer characteristics and make no assumptions about the type or amount of services that those characteristics implied.

It turned out that, once the groups were created, they consisted of three underlying dimensions of the consumer’s (1) level of risk, (2) level of engagement with the mental health system, and (3) level of skills and supports. The consumer’s **LEVEL OF RISK** is comprised of three primary factors: 1) the consumer’s likelihood of causing physical harm to self or others, 2) the consumer’s level of participation in risky or unsafe behaviors, and 3) the consumer’s level of co-occurring disorders. The consumer’s **LEVEL OF ENGAGEMENT** is the degree of “connection” between the consumer and the mental health service system. Note that level of engagement does not mean amount of service. A consumer who willingly makes appointments once per month and works on improving his life should be considered more engaged and

connected than a consumer who passively attends groups on a daily basis. Similarly, a consumer whose only services are large numbers of involuntary hospitalizations but refuses all voluntary treatment would be considered to have no or minimal engagement. Finally, the consumer's **LEVEL OF SKILLS AND SUPPORTS** should be viewed as the combination of the consumer's abilities and support network(s) and the level to which the consumer needs staff support to meet his/her needs. It should include an assessment of their skills in independent living (e.g., grooming, hygiene, etc.), cognitive impairments, whether or not they are engaged in meaningful roles in their life (e.g., school, work), and whether they have a support network of family and friends. It should also include their ability to manage their physical and mental health, finances, and substance use, etc., and their ability to meet their needs for intimacy and sexual expression.

Again, it is important to note that we didn't start out with these dimensions. Nobody said, "We are going to create a system based on these three dimensions." They arose from the natural groupings that people in the mental health field (consumers, clinicians, advocates, and administrators) had experienced in their professional and personal lives, a fact that we believe gives the scale a certain credibility and validity. Although many other important dimensions have been suggested to us by both clinicians and consumers, none of them substantially add to the power of the MORS to differentiate clusters of consumers and all of them add more time and complexity to the tool. We created an extremely brief tool that could be easily used even if it is not completely comprehensive.

The groups that arose were given the following labels:

(A copy of the scale with the complete category descriptions appears at the end of this paper)

1. Extreme Risk
2. High Risk / Not Engaged
3. High Risk / Engaged
4. Poorly Coping / Not Engaged
5. Poorly Coping / Engaged
6. Coping / Rehabilitating
7. Early Recovery
8. Advanced Recovery

It should be mentioned that the scale originally consisted of 6 categories rather than 8. We were reluctant to include the "Extreme Risk" category for fear that people would overuse it. Also, the original version did not include a category of "Advanced Recovery" to describe individuals with mental illnesses who are doing very well and have either never been a recipient of public mental health services or have successfully "graduated" from the public mental health system. The lack of this category was pointed out to us by Kathleen Crowley (author of "Procovery") and probably resulted from the fact that the original focus of our CASRA workgroup was with the population of mental health consumers who were either currently receiving public mental health services or obviously needed services but were not receiving them (e.g., individuals who had a mental illness and were homeless. At that time, neither recovery without services nor graduation from services was part of our experience.

The manner in which the three underlying dimensions are expected to co-vary across the 8 groups can be visualized in the following table:

Milestone	Risk	Engagement	Skills and Supports
1. Extreme Risk	5	n/a	0
2. High Risk / Not Engaged	4	0	1
3. High Risk / Engaged	4	1	1
4. Poorly Coping / Not Engaged	3	0	2
5. Poorly Coping / Engaged	3	1	2
6. Coping / Rehabilitating	2	0/1	3
7. Early Recovery	1	0/1	4
8. Advanced Recovery	0	0	5

This table reflects our expectation that individuals will decrease their level of risk in a fairly linear fashion as their recovery progresses (i.e., the number in the “risk” column decreases). Similarly, we expect the individual’s level of skills and supports to increase linearly as he recovers (again, the number in the “skills and supports” column increases). However, the Engagement dimension does not follow the same linear course. Generally, individuals will be less engaged with the public mental health system early in their recovery and will increase their engagement over time, only to decrease their engagement as professional supports are replaced by natural supports and interdependence in the latter stages of recovery.

While the concepts of risk and skills and supports are relatively straight forward, the concept of engagement is difficult and probably creates the greatest confusion in our classification system. Despite our attempts to make the milestones as objective as possible, assessing the consumer’s current milestone requires interaction between service recipient and service provider and is therefore somewhat dependent on the provider’s characteristics as well as the characteristics of the individual being served. For example, risk might tend to be assessed generally higher in a clinic where a staff member was recently injured by a consumer. Or a consumer may be judged to be “poorly coping” when she could be rated “coping / rehabilitating” if the program offered more support in the community.

However, our experience suggests that level of risk and the level of skills and supports are relatively easier to assess reliably than level of engagement. Because it is the provider who is judging the level of the consumer’s engagement, it is possible for a consumer to be judged as “not engaged” because there are no services being offered that meet the consumer “where she’s at.” The classic example of this is a consumer who is denied mental health services because he refuses to be abstinent for some time period prior to being served. Such a consumer might be very willing to engage with a provider if this requirement was not imposed. But staff in such an environment is likely to view this response as an example of “treatment resistance” (i.e., lack of engagement) rather than as a something lacking in their service spectrum/culture.

Traditional mental health service providers usually evaluate consumers according to their levels of compliance with treatment and insight into their illness. As we define it here, *engagement is not the same as insight*. We are aware of and familiar with many consumers who do not believe

that they have a mental illness or a psychiatric disability of any kind. Yet these consumers may be highly engaged with the staff members who are providing them with service. Usually this is because the relationship is based on helping the consumer to achieve some very concrete goals. These goals may require the consumer to examine (and change) any *behaviors* that are interfering with the attainment of the goal, but that is not the same as requiring the consumer to acknowledge that his mental illness is the *cause* of those behaviors. For example, one consumer who was tortured by the idea of a machine sending destructive rays into his head improved dramatically – going to work and getting off the street and into his own apartment – when he discovered that the rays bothered him less when he took medication and stopped using street drugs. But he never had to acknowledge that the machine was a symptom of schizophrenia.

Similarly, as we define it here, *engagement is not equivalent with treatment compliance*. Many consumers have strong opinions about their services, particularly when it comes to their medications. Some consumers adamantly refuse the medications they are offered. In our definition of engagement, it is possible to refuse medications completely and still be engaged with one's treatment providers. An example of this would be a consumer who refuses medication, but otherwise participates willingly and enthusiastically in other aspects of his treatment. Conversely, it is possible to be completely compliant with one's medication prescription and yet not be considered engaged with one's providers. An example of this would be a consumer who passively takes the pills they give her at the Board and Care, but refuses all contact with her treatment provider.

To us, engagement means working with service providers out of your own motivation in any way that is contributing to your recovery. In most cases where a consumer would be described as "engaged," the consumer would typically be more accepting (rather than rejecting) of the help offered by mental health staff. This does not mean that the consumer passively accepts direction from the staff. What it means is that the consumer accepts the PRESENCE of the staff and continues to work with them even in those circumstances in which there are major disagreements between consumer and staff about what the consumer needs. Engagement does not require that the relationship between staff and consumer is positive or even neutral. The consumer may verbally abuse staff while remaining engaged with them.

Note also that the fact that a consumer is court-ordered to receive treatment does not automatically mean that she is not engaged. Regardless of the circumstances that bring the consumer into treatment (voluntarily or involuntarily), it is still the quality of the relationship with the provider that determines level of engagement. There are many consumers who began their treatment involuntarily as a condition of their probation or parole who respond quite positively and cooperatively to their mental health providers. These individuals would be considered engaged, even though they are required to be in treatment.

All of these factors contribute to engagement being the most difficult of the three dimensions for raters to agree upon. For example, the staff at one clinic that decided to employ the scale without any training independently decided that engagement was equivalent with compliance. This resulted in the decision not to rate any consumer who was not medication compliant any higher than 4 (poorly coping/not engaged), even though a consumer might be doing very well regardless of the lack of medication compliance.

Notwithstanding these difficulties, we continue to believe that the quality of “being engaged” (or “not engaged”) is an important and real factor that significantly contributes to our understanding of and ability to assist the recovery process. Without a working relationship (i.e., “engagement”), our only means to influence the consumer are involuntary treatment and services. While these services may sometimes be necessary to keep consumers safe from harm, these services usually don’t result in the kinds of long-term changes, either cognitive, emotional or behavioral, that typify recovery.

From a system evaluation standpoint, it is also important to have categories that allow us to include consumers who are not engaged with mental health providers (e.g., homeless individuals with a mental illness). The engagement dimension provides us with a means to evaluate the effectiveness and efficiency of programs and systems in their ability to convince consumers to accept our services.

The table above also reflects our expectation, and we now have some data to confirm this, that these three dimensions are quite strongly related to each other. For example, while it’s possible to become more engaged without lowering one’s level of risk, and it’s possible to decrease one’s level of risk without building skills and supports, these changes usually occur together. Also, not all imaginable combinations are very likely to exist; for example, it would be unlikely to rate an individual as “at extreme risk, well engaged, with high skills and supports.” And not all combinations are important to differentiate; for example, if someone is at extreme risk, does it really matter what their level of engagement or skills and supports is?

The manner in which the dimensions co-vary is important because it suggests that calling the MORS a “scale” is, in some ways, a misnomer. It is probably more accurate to think of it as a set of clusters. Even more important is to recognize that it is not a linear, uniform set of stages through which an individual passes on his way to recovery. It has been our observation that individuals will jump around from one milestone to another. For example, a hospital that pays special attention to community treatment engagement can help individuals progress from “Extreme Risk” (1) to “High Risk / Engaged” (3) without going through “High Risk / Not Engaged” (2) and thereby lower their risk of returning to the hospital. Similarly, it’s usually preferable to avoid the “Poorly Coping” categories (4 and 5) on the way up because consumers can often become stuck there. Unfortunately, individuals can also move from a higher milestone to a lower milestone. In our experience, the path of recovery is not always smooth and positive.

### **Reliability and Validity**

Over the last two years, we have been conducting reliability and validity studies with the MORS. The initial results have been very positive, with an inter-rater reliability co-efficient of .85 and test-retest reliability of .90. The MORS is also strongly correlated in the predicted direction with several other instruments, including the Level of Care Utilization System (LOCUS) and the Multnomah Community Ability Scale (MCAS). We have also found that the consumer’s milestone of recovery is highly correlated in the expected direction with his objective quality of life indicators such as residential and employment statuses as well as hospital and jail tenure.

## Uses of the Scale

In discussing possible uses of the MORS, it is important to clarify is that the scale was designed as an *administrative* tool rather than a clinical tool. As mentioned earlier, we believe that the path of recovery is extremely idiosyncratic, particularly in regard to individuals' internal subjective experience. The scale is not intended to provide specific guidance to clinicians in their day-to-day work with their clients. Staff must still consider the particular reasons why a particular client is considered to be "high risk" and provide services based on the consumer's unique needs. For example, one consumer may be constantly abusing drugs and alcohol, another may be paying no attention to her HIV positive status, while another may be inflicting cuts on himself. While all of these individuals would be likely to be considered "high risk," the particular interventions that a clinician would use will no doubt be different in all three cases.

(Having said that, we will point out that many of the case managers at our own Village program have mentioned that the scale gives them a broad and general picture of what "recovery" looks like. They tell us that the descriptions of the higher milestones (6 and above) help to remind them of some of the features of recovery (such as meaningful roles, a natural support network) and this gives them a general framework from which to assist their consumers to individualize and personalize their own recovery goals. We consider this to be a significant advantage that adds to the appeal of the scale.)

We have identified two major uses for the MORS: 1) to assist administrators and funding sources in evaluating the effectiveness of mental health programs and systems, particularly the effectiveness of what are being called "full service partnerships" under the MHSA, and 2) to ensure that we are comparing "apples to apples" in judging the relative need of the consumers that we serve and ensuring that they receive the appropriate level of services. We will address both of these uses in greater detail.

### 1. Evaluating Program/System Effectiveness

It has been said that one of the strengths of the AB 34/2034 program has been its ability to demonstrate the effectiveness of its services by collecting Quality of Life data. The "data grids" published every month demonstrate how successful counties and agencies are in such quality of life domains as reducing homelessness, hospitalization and incarceration and increasing employment and education. Very importantly, it allows the administrators of the individual programs, as well as the state DMH, to compare their outcomes with the outcomes of similar programs across the state. In a similar fashion, the most obvious and straightforward use of the MORS is to allow programs and systems to easily and quickly evaluate their effectiveness in helping consumers to recover. In a sense, a consumer's movement up or down the MORS scale over time can be seen as a "shorthand" indicator for improvement or decline in promoting recovery itself.

For example, imagine a group of 100 consumers who are evaluated as "high risk / engaged" (Milestone 3) upon admission to Program X. After one year in the program, what percentage of these consumers has moved to a higher milestone and what percentage is at the same or a lower

milestone? How many of these consumers are at milestone 6 (coping/rehabilitating) and above and how many are at milestone 5 (poorly coping/engaged) and below? Where are people getting stuck? Most importantly, how does the movement across the milestones for the 100 consumers in Program X compare with 100 consumers who were evaluated as “high risk/engaged” when they were admitted to Program Y?

We believe that the answers to these types of questions will prove extremely helpful to program administrators trying to improve the quality of their services. One of the difficulties in measuring program effectiveness in the mental health field has always been the lack of benchmarks. There are very few data available to inform us about what are “good” outcomes when it comes to recovery. For example, what percentage of the individuals who enter a full service partnership at Milestone 3 (high risk/engaged) should we expect to reach Milestone 8 (Advanced Recovery) within one year of their admission? Within 2 years? Within 5 years?

The fact is nobody knows the answers to these questions. We have no data because we have had no way to reliably quantify the recovery status of the consumers in our system. The MORS rating provides a means for program administrators to compare the effectiveness of their own program to all other programs using the scale. It will also allow system administrators and funding sources to compare the performance of different programs within their systems and thereby hold providers accountable for their outcomes.

## 2. Assignment to level of care (Case Rating) with the MORS

One of the most intractable problems in our current mental health system is our inability to compare the relative needs of different consumers. This is important because it makes it extremely difficult for funding sources to hold providers accountable for their performance. For example, traditional outpatient service providers sometimes claim that their performance should not be compared to the performance of an intensive case management program because the average caseload of their staff members is significantly higher. While this is no doubt true (we have heard of caseloads of up to 150), it is our belief that the average milestone of recovery of the consumers in these traditional outpatient clinics is likely to be much higher than the average milestone of the consumers in intensive case management programs. In other words, a much higher proportion of the individuals being served in intensive case management programs would be rated 5 (“poorly coping/engaged”) and lower than in traditional outpatient clinics.

We believe that the mental health system desperately needs a better means of assigning consumers to their appropriate level of care to replace the diagnostic and acuity of illness-based tools being used today. We believe that the MORS is ideally suited to serve as a recovery-based tool for identifying the level of service needed by consumers. What follows below is one possible system in which the level of services provided to consumers could be determined according to their milestone of recovery.

<b>Milestones of Recovery Levels of Service (Recovery Based Spectrum of Care)</b>						
Extreme risk	Unengaged		Engaged, but not self coordinating		Self-responsible	
Locked settings (State Hospital, IMDs, etc.)	Outreach and engagement	Drop- in center	Intensive case management	Case management team	Appointment based clinic	Wellness center
Extreme risk (1)	High risk, unengaged (2) Poorly coping, unengaged (4)		High risk, engaged (3)	Poorly coping, engaged (5) Coping, rehabilitating (6)	Coping, rehabilitating (6) Early recovery (7)	
1:1 supervision Legal interventions Community protection Acute treatment Engagement	Welcoming/Charity Evaluation and triage Documentation Benefits assistance Accessible Medications Drop-in services		Case management Full Service Partnership Accessible medications Supportive services (Supported Housing, Employment, Education) Direct subsidies Rehabilitation		Appointment based therapy “Medications only” Wellness activities (WRAP) Self-help Peer support Community integration	

Fortunately, in our view it is not necessary to have a different level or type of service for each of the different milestones. The first row of the table shows the four general categories into which we believe the consumer population can be assigned for service provision purposes: (1) Extreme risk, (2) Unengaged, (3) Engaged, but not self-coordinating, and (4) Self-responsible. The second row shows the type(s) of programs/facilities most likely needed by consumers in that particular category. The third row shows the specific milestones that make up the broader general categories. Note here that “Coping/Rehabilitating” (6) appears in both the “Engaged, but not self-coordinating” category as well as the “Self-responsible” category. Finally, the fourth row shows some of the specific kinds of services that should be available and offered to each of the subpopulations of consumers.

This type of system for assigning consumers to a level of care based on their milestone of recovery will go a long way toward promoting system accountability. It will enable system administrators to make meaningful comparisons between programs by ensuring that the programs being compared have the same “case mix” of consumers. It will help us to triage individuals to the programs that can best serve them and indicate which programs should be collaborating with each other because they are working on the same level of recovery. It will

also promote the flow of consumers through the system by establishing benchmarks for when consumers should move to a lower (or higher) level of care. This will help to eliminate the problem of consumers remaining in intensive case management programs long after their need for this level of service has passed.

### **Consumer and Staff Reactions**

It is important to point out that some consumers have expressed a number of concerns about the MORS. Some consumers have expressed that they feel that it is inappropriate for non-consumers (e.g., the authors) to define their recovery for them. They say that it feels disempowering and not respectful of their individuality. As we have tried to make clear in this paper, the milestones are not intended to replace the consumer's individual experiences of recovery or the need for individualized goal setting and service planning, but rather for tracking the correlates of recovery to assess staff and program effectiveness.

Other consumers have expressed that these milestones are just another way of assigning individuals to "low functioning" and "high functioning" groups in order to decide who should be given what services. We don't believe that recovery-based classifications give staff the authority to override the consumer's choices any more than clinical considerations do. But they are a way of *clarifying the nature of the collaboration between staff and consumer*. Being aware of where individuals are in their recovery process can clarify how to handle common conflicts that sometimes arise between staff and consumers. For example, if a consumer wants to be driven somewhere and staff wants to teach him how to take a bus to get there, it helps to know what his level of skills and supports are. This also applies if he wants to be his own payee and staff doesn't think he is ready. On the other hand, if the staff wants to hospitalize a consumer or give her a life coach for overnight crisis support and the consumer believes she can manage on her own, the issue isn't just skills and supports, but also risk. This consideration of risk may also apply to getting off medication management. A final example is when a consumer complains that staff used to buy them lunch and now they won't – it may be that the consumer's level of engagement has changed from not engaged to engaged.

Recently we encountered a clinic that has been rating its clients with the MORS and is now using the milestones as a shorthand way to describe consumers: "She's a three." "He thinks he's a 7, but he's really a 5." While we are pleased staff are thinking in "recovery terms," (and certainly that is better than GAF scores or referring to consumers as "high utilizers"), we are concerned at the dehumanization this implied. We doubt that the creators of diagnostic schemas intended to turn individuals into "borderlines" and "schizophrenics" any more than we intend to turn individuals into "3s" and "5s," but it is a real risk. In our training on the MORS we express our concern that the scale not be used in this manner, but any categorizing tool can be used to replace really getting to know an individual and this tool is no exception. It is our belief that it is primarily the overall culture of a program that determines the manner in which staff generally treats consumers. Administrators who choose to use the MORS will need to ensure that their agency/program culture is consistent with a positive view of recovery.

The MORS has also had a number of positive reactions. For example, several programs with whom we have worked were having real trouble simply visualizing recovery. It just seemed too

vague a concept – until they saw the scale, which appeared to provide some staff with a powerful vision of what recovery might look like.

Another county used the scale to create a map of their system by determining which milestone(s) were the target groups for different programs. They were then able to see where individuals should be initially triaged to, rather than just sending them where it was easiest. Rather than keeping individuals in the same program indefinitely, they could see how flow could occur within their system by determining which programs each of them should be referring on to as individuals recovered and which programs should be their backup if individuals deteriorated. They could also see holes in their system and why certain programs were getting overwhelmed.

Other clinics are using the MORS to evaluate caseloads to help identify individuals who may be better served in an ACT program or a Wellness Center than in a standard outpatient program.

### **Present and Future Development**

Overall, we have been pleasantly surprised at the mental health community's response to the MORS and we plan to continue to develop training materials for it and study it. Currently, the MORS is being used by the Village Integrated Service Agency where all consumers are rated by their personal service coordinators once per month. To ensure that the results at the Village are not an anomaly, we are also conducting a reliability study on the MORS with Vinfen Corporation, the largest non-government provider of behavioral healthcare services in Massachusetts. Vinfen is conducting an initial pilot study at four of its sites and, assuming that the reliability of the instrument is acceptable, plans to use the measure agency-wide beginning in July, 2006. We are hopeful that the data generated by Vinfen will help to demonstrate the broad usefulness of the MORS and the universality of its underlying dimensions.

The MORS is already being used at two of the seven clinics in Los Angeles County that have been tapped for transformation under the MHSA. Training on the MORS is also planned for 2 more of these clinics in the coming months. Ultimately, we plan to make the scale available for all seven of the clinics.

We are hopeful that other programs and systems will find the MORS useful and will adopt it as a means of evaluating their effectiveness in assisting their consumers to recover under MHSA. We invite others to share their experiences with it and we will be pleased to provide training and consultation on its use.

CONSUMER'S NAME:

MIS #:

RATER'S NAME:

DATE:

### MILESTONES OF RECOVERY SCALE

Please circle the number that best describes the current (typical for the last two weeks) milestone of recovery for the member listed above. If you have not had any contact (face-to-face or phone) with the member in the last two weeks, please check here  and do not attempt to rate the member. Instead, simply return the form along with your completed assessments.

1. "Extreme risk" – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.
2. "High risk/not engaged"- These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.
3. "High risk/engaged" – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.
4. "Poorly coping/not engaged" – These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.
5. "Poorly coping/engaged" – These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.
6. "Coping/rehabilitating" – These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing "non-disabled" roles. They often need substantial support and guidance but they aren't necessarily compliant with mental health providers. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be "testing the employment or education waters," but this group also includes individuals who have "retired." That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.
7. "Early Recovery" – These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.
8. "Advanced Recovery" – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbors.

# Creating a Recovery Transformation Plan

By Mark Ragins, MD

At some point, to transform our system, we have to stop planning and discussing, and actually do something different in our day to day work. Naturally, we hesitate at that point. On the one hand, it seems that any single change is tied to so many other needed changes that it's impossible to do anything. On the other hand, it's impossible to change everything at once.

Our approach is to begin by making a set of focused changes that are spread across all the domains that need to be addressed for change to endure. We've chosen to focus on ten goal areas within four domains of change. We've chosen these goal areas both because they are practical and because they're likely to lead to true transformation. Every staff member is expected to choose one of the domains and their included goal areas to work on, while including consumer and family involvement. Each clinic has the freedom to approach these goals as they think best. You must make concrete plans for each goal area, including outcomes, timelines, and needed support. Clinics are encouraged to learn from each other, but we expect all plans to be unique.

Here is an overview of the domains and goal areas:

<p><b>Staff Transformation</b></p> <p>1) Develop and enhance staff belief in recovery</p> <p>2) Energize and instill hope in staff</p>	<p><b>Organizational Structures and Processes</b></p> <p>5) Collect and use Quality of Life and Recovery Based outcomes</p> <p>6) Develop structure to promote client flow and graduation from services</p> <p>7) Build strong teamwork</p> <p>8) Build relationships with Administration</p>
<p><b>Staff-Consumer Interactions</b></p> <p>3) Develop welcoming environments</p> <p>4) Develop successful strategies to work with challenging individuals</p>	<p><b>Available Services / Capacity</b></p> <p>9) Develop quality of life support services</p> <p>10) Collaborate with other social services</p> <p>11) Develop community belonging</p>

Which box looks good to you?

Here's some background and ideas to help you get started:

## **Staff Transformation:**

It's clear that the heart of any program is the staff. Our system is certainly in need of major changes, but if, in the end, we change the system and don't change ourselves, nothing will really change.

### *1) Develop and enhance staff belief in recovery*

Recovery is so different from what any of us were taught in school, what we were trained to do, what MediCal requires, what the system has been set up to deliver, what our professional organizations espouse, and what we've personally experienced in our work, that it's hard to visualize. With such a contrary background, it's hard to believe recovery is regularly possible, let alone to make major changes to promote it.

We need to create a positive background on the fly. There is good research data. There are compelling speakers describing their own recoveries. There are programs promoting recovery that are true believers. There are probably even good examples of recovery and your ability to promote recovery in your past and present work. Calling up and reconnecting with people who left the clinic doing well can also be inspiring. Choose what you want to do.

Another very different kind of experience that builds belief in recovery is to work alongside people with serious mental illnesses in recovery, not as limited "consumer staff" with limited roles and expectations, but as full colleagues.

### *2) Energize and instill hope in staff*

Recovery work is very emotionally intense work because it relies so heavily on personal relationships to be effective. It also requires lots of supported risk taking and giving up considerable control and structure to people with a psychiatric diagnosis. Most of the staff concerns are connected to this combination of increased investment and decreased control. Trying to minimize risks or retain control will seriously handicap recovery efforts. Therefore we're left with trying to strengthen staff.

Fortunately, most staff have a lot of untapped strengths. The current system seriously restricts staff and attempts to create productivity by turning staff into assembly line workers. There are substantial emotional strengths from life experiences that have been cut off as "unprofessional" that can be tapped into. There are also lots of other strengths people have (for example dancing, hiking, spirituality, child rearing, charity work, athletics, politics, etc.) that can also be tapped into.

We also have a tendency to focus our attention on negative events and crisis creating a daily atmosphere of "impending disasters waiting to happen" instead of focusing on celebrating positive outcomes and pleasant surprises. Instilling a hopeful culture will lead to more willingness to take risks and decrease control.

## **Staff-Consumer Interactions:**

The majority of our success and failure (including medications) depends on staff-consumer interactions. Although there are many people with whom we establish good working relationships, with many others we don't. We struggle engaging some people; others drop out without much benefit, and others fight with us throughout. Even though part of us is grateful not to have even more people to deal with, this dissatisfaction and aggravation takes its toll.

### *3) Develop welcoming environments*

We have developed a host of practices designed to keep us from getting overwhelmed by new clients, to keep us from getting hurt by all these strangers coming in, and to make sure everyone is adequately documented to bill efficiently. These practices are seriously handicapping our ability to engage new people in positive relationships and need to be systematically re-evaluated and changed. Even people we turn away should be initially welcomed.

Once people are known to us, we need to share our program and our building with them. The traditional model where the office belongs to the doctor, or other professional, and the patient comes to visit, waiting patiently outside with the other visitors until they are allowed in needs to be transformed into a shared environment that can serve as a safe sanctuary, a place of acceptance and healing, a place to connect with others who care about each other, a recovery community. Remember the old "therapeutic milieu"? Remember when groups were part of creating larger relationships and not the only place to connect in an impersonal clinic?

### *4) Develop successful strategies to work with challenging individuals*

A small number of people create an enormous portion of the problems in any program and take lots of time and energy away from everyone else. Some of these people are essentially "unengaged" in treatment despite being given lots of treatment. They are frequently brought in by others coercively or come in demanding in crisis requiring immediate attention. Others are "engaged, but not self-coordinating." They are trying to improve their lives, but everything is always a mess. Substance abuse and poor usage of medications are frequently part of the picture. Sometimes homelessness, jailings, or frequent hospitalizations complicate things further. These people do not do very well in the traditional, appointment based, outpatient clinics they are often in. They never get enough support, in an ongoing, intensive, proactive, flexible way to improve enough to be "self-responsible" enough to be well treated in an appointment based clinic.

A number of strategies including ACT teams, walk-in clinics, harm reduction, motivational interviewing, payee programs, medication management, and assertive outreach have been developed.

## **Organizational Structures and Processes:**

Many staff feel like they are working all alone or with a few trusted colleagues, fighting oppressive bureaucracies and auditors, relatively weak and unheard, powerless to effect major changes. Few have experienced the increase in power that comes from being in a system where the structure and processes are in alignment with what they value. Systems work better when everyone is going the same direction instead of where everyone is building small, walled off, embattled areas of their own.

### *5) Collect and use Quality of Life and Recovery Based outcomes*

Our present system has virtually no outcome measures. Instead it measures “units of service” and analyzes chart notes. We will only be able to impact that system when we can replace it with a reliable outcome accountability system. It is important for us to measure what we want to create, quality of life and recovery, so we’re going in the same direction. Measurements have a way of making things real.

Quality of Life measurement tools have been developed by the AB2034 program to assess housing, employment, income, legal status, education, and involuntary treatment (conservatorship, hospitalization, and institutionalization). These are very powerful political measurements and saved the funding of the AB2034 program from the governor’s blue pencil. They will be included in the MHSA funded programs. The forms are easy to fill out, and it may be possible for people to fill out their own forms when they come into the clinic.

A recovery based outcome tool has been developed at MHA and is getting substantial attention. Several of the clinics have already begun rating the “stage of recovery” of their clients to focus them on recovery needs. It is also reliable and easy to use and can help assess case load needs and individual progress.

It is crucial that any data that is collected is returned to the staff and consumers that collected them to be used. Otherwise any measurement tool is just another added burden to be resented. A feedback loop must be built in.

### *6) Develop structure to promote client flow and graduation from services*

The most dangerous problem that transformation faces is the overwhelming case loads. We have a system where more people come for help everyday and very few people leave successfully. Over time, any such system will become overwhelmed. There is no staffing level large enough to avoid that fate. That is not to say that we don’t need more staff. We do. But unless we create flow we will never catch up.

Every service must be designed to be transitional (though not necessarily time limited) and there must be a set of “next steps” that people progress to if they do well. This can range from outreach services achieving engagement; then the person moves on to case management; then to outpatient therapy achieving self-help coping skills and natural community supports; and then the person moves on to self-help support without a

therapist or case manager. A “flow map” of the overall program should be created. (Note that it’s not a linear map and people unfortunately sometimes flow backwards.)

A crucial feature of the map is that there must be destinations outside of the clinic entirely. This may include private MediCal or Medicare providers, HMOs, sliding scale therapists, self-help programs, other social service agencies, community supports and no treatment needed at all. (At the Village, we were unable to identify or develop adequate outside destinations and resorted to creating an independent Wellness Center as a graduation destination. It is likely that DMH will create Wellness Centers in every service area to meet this need.)

Flow and graduation generates an impressive amount of distress and conflict among staff, clients and families. It is likely that after the organizational structure and processes group does its job and creates a structure for flow and graduation, the staff transformation group will need to address the issues that emerge.

#### *7) Build strong teamwork*

Teams are not included in this list of initial goal areas as a fashion statement. Strong teams are crucial to the ability to lower boundaries without ethical violations, to take on multiple roles with multiple clients, to insure physical safety in unlocked environments, to expose ourselves to painful emotions encountered in close relationships with clients without being overwhelmed, to be accessible for walk-ins, work in the community, and keep appointments responsibly all at once. Equally crucial to teamwork is the ability to have multi-disciplinary expertise including non-professionals, consumers and families, to have a multi-experiential background to engage a variety of difficult people, and to have cultural diversity and competence. The plan in this goal area must go beyond generic team building to address all of these crucial needs.

#### *8) Build relationships with administration*

There is a longstanding mistrust and distancing between line staff and administration. Staff tends to have trouble believing that any initiative is real, let alone that they will get the ongoing administrative support needed to implement transformation. Administration tends to have trouble believing that staff will actually implement any changes without being ordered to do so and told specifically what to do. Nonetheless, the best work plans are likely to come from the staff that has to implement them and the best motivation comes from empowering staff. The plan in this goal area needs to address how administration and staff can come closer together, trust each other more, and work collaboratively, being sensitive to each other’s needs and pressures.

## **Available Services / Capacity:**

Many staff express a frustration that they can't help people achieve quality of life goals without the needed services and capacity. What good is it to help someone get motivated to get their own apartment or a job if there aren't any apartments or jobs available? The tendency is to return to dealing with mental health where we aren't so dependent on things we don't have and can't control. Unfortunately, that leaves the clients with nothing.

### *9) Develop quality of life support services*

It's been shown repeatedly that mental health services on their own rarely lead to quality of life achievements like income, housing, employment, or education. This is partly because people with serious mental illnesses often need ongoing support along with skill building to "choose, get, and keep" these things, and partly because there are pervasive shortages of opportunities in our community. Therefore, services need to include skill building, support, and community development for each of these achievements.

Generally skill building and support staff should be integrated into the service teams so they have relationships with the clients and their services are easy to access, while community development staff need to spend most of their time in the community creating relationships with landlords, employers, educators, etc.

### *10) Collaborate with other social services*

There are a variety of social service agencies designed to assist people with improving their quality of life. Some of these are well known to us (for example SSI, Voc Rehab, HUD, county health services, GR, substance abuse services, and regional centers) and some are more obscure (for example IHSS, meals on wheels, dial a lift, disabled student services at community colleges, family preservation services, mental health advocacy services, library literacy classes). A good plan will increase the number of social services being used by our clients.

Unfortunately, most of these services have serious problems of their own and are difficult for people with mental illnesses to access or use successfully without accommodations. Many of them have developed specific mental health programs as a result (for example GR's NSA program, HUD's shelter-plus program, Voc Rehab- DMH co-op program, dual diagnosis programs, collocated MH worker at the jail). Utilizing these services is a strategy for expanding what would be possible with direct clinic staff alone, but personal relationships are the glue that makes programs like this work, and we need to invest in assigning staff to make those relationships.

### *11) Develop community belonging*

Perhaps the most challenging goal area is to develop community belonging. Yet, true recovery requires people attaining meaningful roles that are not "service recipient." Staff, families, and even the clients themselves all tend to have problems visualizing our clients in these other roles. Making things worse, many staff are also uncomfortable

working in the community outside of our provider roles. Community development is a rare skill. Part of this plan should be making a “community map” of potentially welcoming places in our community (for example YMCA, bowling leagues, churches, volunteer organizations, Park and Rec classes, singles’ groups, etc.)

The available services/capacity group has the difficult job of determining how to create new services and capacities. Three general strategies are available: First, they can re-allocate existing staff and resources. Transformation requires both creating some new services and destroying some old services. It may be that with a change in mission some services are lower priority than they used to be. Second, they can leverage resources from other community agencies. Using volunteers are an example of this (for example mentors or ComPeer), but even volunteers require an investment of staff to coordinate them. Third, they can make specific requests for upcoming MHSA resources.

Now which group looks good to you?

## **Recovery-Based Service Delivery**

By Mark Ragins, MD

Recovery based programs pride themselves on treatment planning and service delivery that is “consumer driven.” We don’t assume we know what’s best for people. We don’t tell them what they have to do or limit our help to what we think is right. We try to support them as they find their own path to recovery.

But the day to day reality isn’t that straightforward. We don’t actually support every goal people might create – for example killing your family or using lots of drugs while we pay their rent and help them get off when the police catch them. We do try to persuade people do what we think would be helpful. Sometimes, like with payees or medication management or hospitalization we even coerce people. We do have some overall vision for what we’re trying to accomplish.

Reality is closer to “value driven and consumer centered.”

We have some values that are socially driven, like cost containment, not bothering the neighbors and increasing the safety of our community. We need to promote these values to stay in business. We have some values that are Quality of Life driven like housing, staying out of jail and hospitals, finances, employment, education, physical health, etc. These values are incorporated into our Outcomes and we’re held accountable for them. We also have some values that are recovery based. We want people to recover. We’re trying to be accountable for recovery progress with the Milestones of Recovery tool.

Service coordination at its best is an effort to promote those values along a path that is centered on each person’s choices.

In the same way that traditional mental health programs prescribe certain treatments based upon people’s diagnosis and case management/rehabilitation needs, recovery-based programs base their services upon people’s recovery stage, quality of life goals, and society’s needs. When we get into disagreements with the people we serve about what service they want, we can ground ourselves by asking which of the three value sets is generating the conflict. Do we disagree about what would promote their recovery at this point? Do we disagree about how to pursue which Quality of Life goals at this point? Or do we disagree about what is socially acceptable?

Often we’re least sure about where someone is in recovery and how to help them progress.

The Milestones of Recovery tool was designed to help staff reliably describe where someone is along their recovery path. It was built around three dimensions: 1) Risk – Presumably you’re not very far along in recovery if you’re at high risk for more damage. 2) Engagement – This doesn’t mean “compliance with staff treatment and meds.” This means connected with other people around the process of rebuilding. Presumably you’re not very far along in recovery if you’re seriously suffering but not connected with anyone trying to work to improve. On the other end, presumably if you’re far along in recovery you don’t need much professional help and can successfully live with natural supports.

3) Skills and supports – Presumably the more skills you have the better, while the supports you need keep progressing.

As people move through each milestone of recovery their service needs change in all three dimensions: Risk, Engagement, and Skills and Supports. Being aware of where people are in their recovery process can clarify how to handle common conflicts. For example, if someone wants you to drive them somewhere and you want a life coach to teach them how to take a bus to get there, it helps to know what their skills and supports are. This also applies if they want to be their own payee and you don't think they're ready. On the other hand, if you want to hospitalize someone or give them a life coach for overnight crisis support and they think they can manage on their own, the issue isn't just skills and supports, but also risk. This may also apply for getting off medication management. When they complain that you used to buy them lunch and now you won't, it may be that their level of engagement has changed.

Note that these recovery based considerations do not give you authority to override the person's choices any more than clinical considerations did. They are ways of clarifying the collaboration for both of you.

Pursuing quality of life goals may require different services depending on someone's progress in recovery. It's not that they can't pursue certain goals, for example employment, until they've achieved more recovery. It's that the way to pursue their goal changes. For these purposes let's simplify the 8 Milestones into three groups, irrespective of their diagnosis: 1) "unengaged," 2) "engaged, but poorly self-directed," and 3) "self-responsible."

People who are "unengaged" generally do not collaborate in their recovery. They might refuse all treatment, come in irregularly during crises, only want charity and entitlements but not treatment, or be brought into treatment repeatedly or involuntarily for being dangerous or disruptive. People who are "engaged, but poorly self-directed" might want to collaborate in their recovery, but have trouble coordinating the services they need. They may miss appointments, take medications poorly, abuse substances, or have poor skills or support. They need someone to help coordinate their services. People who are "self-responsible" not only collaborate in their recovery, they can coordinate it.

The three groups are not dependent entirely on consumer traits. System traits, primarily "engageability" and "directability," also affect who is in which group. For example, there were many people who went to the Mental Health Association's Homeless Assistance Program who wouldn't go to a local mental health clinic to make appointments and get medications. However, when I started handing out pills at HAP's drop-in center, most of the people wanted to take pills. They weren't really "medication resistant." They were "clinic resistant." When I changed the "engageability" of psychiatric services, many of them changed from "unengaged" to "engaged, but poorly self-directed." Similarly, it is far easier for consumers to coordinate their own services if they are available at one site in an integrated services program, instead of scattered in several separate systems.

Keep in mind that every service is designed to help the person grow into the next stage. For example, you can meet the housing needs of an “Engaged, but not self-coordinated” person with a Board and Care by adding structure, making decisions for people, and taking care of their needs, but this is unlikely to lead to them growing into the “self-responsible” stage. On the other hand, supported housing where you provide for their needs in an apartment setting while training them to do it for themselves both meets their housing needs and is likely to lead to growing into the “self-responsible” stage. All services should be seen as “transitional” but rarely strictly “time limited.” Transitions are likely to lead to the most conflicts as services change. Although transitions can be gradual, staff have to change to keep working with people moving forwards alongside them as they progress

### **Program Differentiation:**

#### Employment:

Stage 1: day labor, “work for a day – house for a day”

Stage 2: agency businesses, supported employment including job development and coaching, group placements, supported mental health employment

Stage 3: non-disclosure competitive employment job development, competitive mental health employment

#### Housing:

Stage 1: hospitals, IMDs, vouchers, SROs, crisis residential, family

Stage 2: Board and Care, drug treatment programs, sober living, supported housing, master leases, IHSS, family

Stage 3: independent living, ownership

#### Finances:

Stage 1: small grants and loans

Stage 2: interim funding, rental subsidies, payee, grants and loans, agency savings accounts,

Stage 3: grants and loans, community bank accounts,

#### Substance Abuse:

Stage 1: harm reduction, motivational interviewing, DDA meetings, referrals

Stage 2: harm reduction, motivational interviewing, DDA meetings, drug treatment and detox programs, sober living, 12 step work

Stage 3: relapse prevention, ongoing 12 step work, giving back

#### Therapy:

Stage 1: engagement, empathy, crisis, drop-in groups

Stage 2: supportive, strengthening, cognitive, relationship, “corrective emotional experiences”, drop-in groups

Stage 3: appointment based individual or group, dynamic, uncovering, self-help (including creating WRAP, advanced directives)

Medication:

Stage 1: med exploration, med trials, high flexibility and accessibility  
Stage 2: med management, long acting injections, high flexibility and accessibility  
Stage 3: self- management, regular appointments

Social:

Stage 1: “accepting” environment in the program, peer outreach, staff organized activities  
Stage 2: peer networking, supported socialization  
Stage 3: community development and integration

Education:

Stage 1: exposure  
Stage 2: supported education, agency classes  
Stage 3: career development

Crisis response:

Stage 1: outreach, crisis walk-in, meet practical needs while engaging, collaborate with coercive services, diverting when possible  
Stage 2: home visits, crisis walk-in, 24 hour emergency hotline, peer run warm line, coordinate support services in the community, “life coaches”  
Stage 3: peer support, peer run warm line, coordinate natural supports in the community, utilize self-directed crisis plans (WRAP, advanced directives)

Services should be chosen by recovery stage, not by what’s easiest to access at the time. Mismatching recovery stage and service, or lacking some of these services, make it harder to promote successful outcomes.

It is possible to collaborate with other agencies to provide more services, but usually not in Stage 1, only when facilitated by a case manager in Stage 2, and independently coordinated by the consumer using referrals only in Stage 3.

People are usually in the same stage for every service they’re receiving, because their stage reflects how far they’ve come in recovery, not how far they’ve pursued any particular goal area. These stages are not intended to be used as prerequisites for each other. People should use whatever stage’s services they’re in at the time. Some people may resist moving on even when they are able.

Notice also that these aren’t the only services possible to offer. This is just a list of what we’ve tried at the Village. I had an interesting conversation with a woman in a planning workshop trying to apply my recovery planning stages to assist the battered Hispanic

women she works with (Unengaged – collocate a mental health worker and a recovered peer at the church where these woman come to talk to the priest and at the ER where they come for medical treatment for their beatings; Engaged but not self-coordinating – have a mental health worker stick with these woman in a motivational interviewing approach when they return to their men and when they’re ready, walk alongside them through the steps necessary to escape the abuse and recover; Self-Responsible – have a work sheet of the steps to take and the resources available and a recovered peer to offer support along the way.)

When delivering services, it’s important to focus not just on what’s done, but also how it’s done. The values behind the practices are crucial. Some values, like consumer inclusion, hope, empowerment, choice, self-determination, pursuing quality of life goals, experiencing non-patient roles, and individualization of services are important throughout treatment and some are more important in certain stages of recovery.

### **Value differentiation:**

#### Stage 1: Unengaged

- There’s “No Wrong Door”: People shouldn’t be expected to understand our system design well enough to go to the right place for what they need themselves. Every entry into the system ought to lead to every service and it’s the responsibility of whoever greets them as they come in the door to get them successfully to the right place.
- Everyone is welcoming: Too often we focus on our tasks of gate keeping and rationing, before we make new people feel welcome. If new people are seen as additional burdens by staff, they are unlikely to greet them with open arms.
- Create a “counterculture of acceptance”: Most people with serious mental illnesses (and substance abuse) experience a lot of rejection from our community. To be helpful, our programs need to accept people that outsiders may not. This is not to say we should tolerate being abused or injured, but many people need a sanctuary of sorts, a place to let down their walls and work on recovering.
- A good treatment is built on a good relationship: Use everything possible to build relationships including charity (e.g. listening, respecting, doing things for people, self-disclosure, sharing non-treatment time and activities).

#### Stage 2: Engaged, but not self-coordinating

- Support, don’t care-take: Staff are often needed intensively to facilitate people getting services and their needs met. This is done with the person not for them, while teaching them the skills to be able to think it through themselves and do it themselves. People will often prefer things being done for them, but that doesn’t promote self-responsibility and recovery.
- Services are mobile: Their lives, their problems, and their goals are in the community not in our offices, so we need to be out there too. Build skills by doing things together where they need to be done, not by talking about how they’re done in the office.

- Services are accessible: These people have serious problems coordinating things, including our appointments. The needed flexibility usually requires a team working together so there's a better chance someone is available
- Integrate services into a "one-stop shop": Having personal relationships with multiple service staff makes it more likely they'll actually access the services they need.
- Be a "no fail" program: Instead of rejecting people or taking over their lives when they do things wrong, focus on how they can learn from their missteps and what changes they need to make. Instead of closing their case when they don't show up, do assertive re-engagement. Go out and find them.

### Stage 3: Self-Responsible

- Create natural, community supports and roles: It's important to work ourselves out of a job. We want to help people find friends to support them, to find places to belong besides with us, to have more meaningful roles in their lives than being good patients.
- Promote self-help: We should teach people skills to manage a variety of symptoms and to get their needs met and connect them to other people in recovery who can support each other.
- Encourage people to "give back": No longer should they be just "consumers" of services. They can give back to our programs and to others in need. They can be role models bringing hope to others. Some even pursue mental health employment.
- Encourage mental health advocacy: Not everyone will want to promote the recovery movement or even disclose their illnesses outside our programs, but those who choose to do so can have a profound impact on stigma and the community's perception of mental illnesses.
- Create "graduation" rituals and services: It's important to have a positive exit from the system (even for people who continue to take medications); there are serious personal issues for both the people taking the risk of moving on and for the caring staff they leave behind that need to be addressed. We need to remember that full recovery is far more common, and far more realistic, than we imagine.

A recovery program can create flow if it pervasively emphasizes growth and movement forwards. This helps both by moving people to higher levels where they do more for themselves and by "graduating" people. Flow and service rationing are inversely related. The more flow we create the less rationing we need. The less flow we create the more rationing we need.

While it may be easier to give a man a fish than teach him to fish, only the teaching creates self sufficiency and flow.

## Designing Transformed Clinics

By Mark Ragins, MD

I have been working with several clinics in Los Angeles over the past year as they have begun to transform themselves while incorporating new Mental Health Services Act programs – Full Service Partnerships and Wellness Centers. Although there is significant individual variation between the clinics, some common design issues have emerged. This paper describes a four-part design and includes some of my thoughts. Hopefully it will be useful to those of you are also working on transforming your clinics.

The emerging design contains four program elements (we’re still working on the names):

Welcome Center	Engagement Triage Charity Supported Referrals “One Session Psychotherapy” Crisis Care – walk-in Medications Substance Abuse Outreach
Full Service Partnership	ACT services Intensive support services (housing, financial, employment, legal, etc.) 24/7 Crisis Care Substance Abuse Medications
Core Support Services	Supportive therapy Problem solving / Case Management Growth Modules (benefits assistance, housing, employment, focused therapy, focused medication, skills training, health care, active substance abuse treatment, parenting, etc.) Crisis Care – ongoing clients Medications Family support / education Graduation preparation (WRAP, etc.)
Wellness Center	Self help / mutual peer support Wellness focus activities and groups Community integration Health care Substance abuse – relapse prevention Crisis care - self directed Medications

We intend to promote active flow through the programs to less intensive / more self-responsible levels of care and even out of the clinic entirely.

Here are some thoughts about each program:

### **Welcoming Center:**

At present after a brief screening everyone who is eligible is given a full clinical and financial assessment and creates a six month treatment plan. This takes about 3 hours and is often an inadvertent barrier to people coming in. After this lengthy assessment and planning many people never return. The redesign attempts to broaden the menu of options. Each person will get a single visit assessment and be offered some help that day. Triage will take place over the course of two months while we continue to help people in the welcoming center, assessing whether the person has a serious mental illness, whether they live in the clinic's area, whether the clinic is the best treatment setting for them, whether they are engaged enough to return to the clinic regularly, and what program in the clinic and even what staff would be best for them. The triage process has an inherent tension between the need to ration clinic resources and refer out and the need to openly welcome people and not set up obstacles to them getting the help they need. The full assessment and treatment plan will be done after the extended triage by the accepting staff.

The Village Homeless Assistance Program developed a triage schema that may be useful:

- Green – The person should be admitted to the clinic. They're eligible and engaged. Chose best program (FSP, Core, Wellness) and assign to "matched" staff.
- Red – The person should not be admitted to the clinic either because they don't have a serious mental illness, they're out of area, or can be served by other providers (e.g. Parole MH, VA, private providers), etc. Give short term help and supported referrals.
- Yellow – It's unclear whether the person should be admitted or not or it's unclear if they are engaged enough to return to the clinic regularly. Continue to help them in the Welcome Center while increasing engagement and further assessing options.
- Blue – The person has been seen in the Welcome Center but has dropped out or been lost. Help again if they return and try to re-engage. Consider outreach.

Staffing would likely include a supervisor / licensed clinician, a community worker / case worker, a substance abuse specialist, and a psychiatrist, working with all the core program clinicians on a rotating basis.

### **Full Service Partnership:**

This program has been largely defined already including ACT services and supported housing, employment and money management, building on the existing AB2034 model.

A key issue that has been emerging is that since the criteria for admission are social rather than clinical (homelessness, jailing, repeated hospitalization, institutionalization, or only avoiding the above because of overwhelmed family support) there will be people the clinic feels are in "need" of this level of service who are not eligible and will have to be treated less adequately elsewhere in the clinic.

There are several important choices available to the program:

- 1) Will case loads be assigned individually or be shared team case loads?
- 2) How will the professional and paraprofessional staff interact and work together?
- 3) Will the support service staff (housing, employment, financial, etc.) be dedicated to their specialty or have case loads too?
- 4) Will the specialty staff primarily focus on developing relationships with the clients or with the community (e.g. their “case load” could be 20 landlords or employers)?

Although FSP case loads are low by traditional clinic standards, it’s amazing how difficult and time consuming this work actually is. There will often be the risk of getting so involved in reactive daily crisis work that proactive growth work is short-changed. Rationing staff time is a constant challenge.

The Village developed a priority guide that may be useful:

- 1) Engagement – First priority is to develop a relationship with the client (actually multiple relationships). Poorly engaged clients are difficult to help in crisis or to help pursue any goals.
- 2) Risk – All crisis are not high risk. The less the staff get in the habit of responding to all crisis as high risk the less the clients will present in crisis to get staff attention. “Pressing” is not the same as “urgent.”
- 3) Ready – When clients are motivated to pursue goals staff should allocate more time to supporting them to obtain their goals. Be wary of staff deciding someone “isn’t really ready” and discouraging clients.

After a year, and flexibly on an ongoing basis, FSP clients should be reassessed for moving on to core services (or, more rarely, Wellness Center). Both staff and clients should view FSP as a transitional program to create a culture that promotes flow. There can be a substantial transitional period of co-enrollment in both programs.

### **Core Support Services:**

The majority of the clients in the clinic are likely to be in this program working with staff with quite high caseloads. It is hoped that by treating “unengaged” clients in the Welcome Center, high intensity homeless, jail diversion, frequently hospitalized, and institutionalized clients in the FSP, and more advanced recovery clients in the Wellness Center that the core support services will become more focused and effective. Nonetheless, it is likely that many clients will be only vaguely known by the staff and receive only modest services.

Within this unsatisfying reality several transformative steps are recommended:

- 1) Clients can be initially “matched” with staff by the Welcome Center rather than being assigned randomly based on what day the intake happened to be.

- 2) The staff can work more as a team so that individuals can receive services from a variety of somewhat specializing staff rather than staff working in de facto private practices as a “Jack of all trades.”
- 3) Specialized services can be organized into time limited, growth oriented modules (for example, benefits assistance, supported housing, supported employment, focused therapy, focused medication, skills training, health care promotion, active substance abuse treatment, parenting, etc.) that motivated clients can access, regardless of who their primary supportive staff is.
- 4) A culture of flow can be promoted by regularly assessing the clients’ stage of recovery and using it, by creating “moving onwards” graduation preparation programs including WRAP and community integration, and by having regular rituals and celebrations of clients’ progress and recovery.

### **Wellness Center:**

Creating an effective and desirable Wellness Center that clients will feel they can rely on and will want to move on to and that staff feel confident graduating people to is essential if flow is to occur. Once again, there can be a substantial transitional period of co-enrollment in both programs.

The fundamental elements of a Wellness Center are being defined by DMH with widespread input. At this point they include:

- 1) Wellness and recovery-focused mental health and supportive services, including emphasis on physical health assessment and linkage to appropriate services.
- 2) Focus on coaching and advocacy and health education.
- 3) Linkage to services that will enhance recovery and contribute to reintegration into the client’s community including academic skills enhancement resources, medication management, psychotherapy/counseling, vocational and employment services, housing services, and primary care services.
- 4) Voluntary participation with potential graduation from participation and/or exit from the mental health system.

Hopefully, we will refine our practice as we learn from our experiences.

My work at MHA’s Wellness Center generated several related concepts that may be useful:

- 1) Consumer Run: Although the Wellness Center includes professionals, including a psychiatrist, it is fundamentally consumer run. The consumer led administration of the program collaborates with the professionals to support consumer goals modeling the desired collaborative individual clinical interactions between the professions and the clients. There are some situations both administratively and clinically in which professionals have increased responsibility but the “default” setting for both levels is self-help and self-responsibility.

- 2) Network Support: The fundamental support relationship is not a case-manager-client relationship. Instead support is mutual, with both give and take, with members supporting each other. The primarily consumer staff has expertise in running self-help groups and activities, providing peer support, developing WRAP plans, and identifying community based network and supports, not in taking care of people.
- 3) Safety Net: The program is intended to be its own safety net. While the Urgent Care Center, Emergency Rooms, Hospitals and even returning to the Village exist; the vast majority of crises are handled within the Wellness Center itself. Some staff may temporarily take some responsibility for members in crisis rather than leaving them entirely to self-responsibility if they are occasionally too impaired to be self-directed. However, the emphasis in all crisis care is on teaching skills to enable the next crisis to be averted entirely or self-directed (e.g. with advanced directives).
- 4) Team Medication Services: In place of the rapid psychiatrist med refills without crisis accessibility most self-responsible clients receive, the Wellness Center uses a nurse practitioner-psychiatrist team to expand medication services. Both do assessments, sometimes together and “know” the members. The nurse practitioner focuses on routine refills, “Wellness Checks” and documentation. The psychiatrist focuses more on supervision, crisis and transitions.
- 5) Getting Even Better: Patricia Deegan wrote “Some people with mental illnesses get well, and then they just keep getting even better.” The primary action of the Wellness Center is not in managing crisis, providing ongoing medication and documentation, or achieving stability, although these are the most urgent reasons for its creation, it’s most costly and heavily reimbursed functions, and its clearest social mandate. The primary action is ongoing growth and recovery for the members “getting even better.” This includes education, employment, wellness strategies, advocacy, self-help, community integration, family, romance, and even deeper psychological healing and spiritual growth.

Overall, this four-part design structure seems possible to implement even with our far from ideal staffing patterns and, I believe, creates a firm foundation upon which truly recovery based programs can emerge.

## **Staffing Full Service Partnership Teams**

**By Mark Ragins, MD**

A substantial portion of the new adult Community Support Services money from the Mental Health Services Act will be going to create new Full Service Partnership Teams. Full Service Partnership (FSP) is a new name designed to build on the concepts of ACT teams and Integrated Service Agencies without constraining ourselves within those models' definitions. FSPs are considered a powerful part of system transformation because they target resources to those people in highest need, they facilitate outreach if needed to help engage people, they accommodate people who do poorly with appointment based services, and they are able to incorporate quality of life support services and funding. Those are all features that are weak in our present system that the transformation is trying to improve.

To actually run a FSP will require programs to create teams that include both present staff in altered roles and new staff. Many of our present clinics run more or less as a group of individual practices with each professional staff responsible for their own caseloads and the services they provide, with only limited sharing of clients and teamwork. Therefore, creating teams will be a change for many current staff.

### **Creating teams offers a number of potential advantages:**

- 1) No one staff is capable of assisting people with the entire range of quality of life services - from employment to housing to money management to health care to legal assistance to family support to education to benefits assistance to substance abuse assistance to community integration - they may need. Without a team they are likely to be offered only whatever services the staff they are assigned to feels comfortable with providing leaving their other needs largely unmet. It is possible for a team of staff to assist people with the entire range of services if the team is carefully assembled.
- 2) If more than one staff member is familiar with each client, it is possible for their primary staff to be serving someone else in the community and still have another staff available to assist them. This makes it possible for staff to combine community, appointment based and walk-in services.
- 3) If staff are assembled that are not just a multidisciplinary team, but also a multi-experiential team they will be able to engage and work with a wider variety of people than any one staff member could. For example the team can include someone that works well with paranoid people, psychotic people refusing medications, actively substance abusing people, drug dealers, depressed, hopeless, unmotivated people, dirty, smelly people, women who won't leave battering men, men who batter women, prostitutes, pimps, thieves, and people with severe personality disorders. It would take a saintly staff member to engage and work with all those people successfully, as we are now expected to do. It is more realistic to expect a team consisting of a variety of caring staff to work together to create a counterculture of acceptance able to engage and work with all those people successfully.

4) Recovery work often depends on staff taking on a variety of roles besides clinician so that the people being served can take on a variety of roles besides chronic mental patient. Recovery work also often depends on staff creating more adult-to-adult relationships with the people being served while including emotional connectedness, guiding, and healing into these “friend-like” relationships. Both of these tasks require altering the traditional roles and boundaries rules that were constructed to protect both staff and clients in private practice, office-based, professional and psychodynamic treatment settings. In order to alter these rules while maintaining strong ethics, personal, emotional and physical safety staff must work in teams. Teammates are needed to dilute transference relationships, give each other emotional strength in times of need, watch each other’s backs to avoid ethical lapses, and protect each other emotionally and physically. If a team creates a strong emotional and ethical matrix, boundaries and roles can be safely lowered and healing relationships dramatically increased.

**However, creating teams also has its challenges:**

1) Many staff and clients prefer individual work. They like the additional privacy and sense of intimate safety that comes with a good individual therapy relationship. It feels easier to open up emotionally. Trust is built that isn’t easily transferred to other staff. It can be difficult for staff to convince new clients of the advantages of a team milieu especially if they don’t believe its better themselves.

2) Many staff are working in programs where they don’t really like or trust many of their teammates. Hiring doesn’t generally have much input from the people who have to be teammates with the new staff. Firing or reassignment are often more dependent on civil service rules, unions, or administrative needs than on compatibility of teammates. While on paper teams have a variety of important strengths, in practice they can easily deteriorate with personal conflicts, antagonism, and forming factions.

3) With high work loads, that sometimes feel like being stuck on a conveyer belt, staff may prefer to try to get their own work done as best possible rather than create a system of shared responsibility that they have less comfort with and control over. Many staff feel that some of their coworkers are slackers likely to give them extra work without reciprocation in a shared system. Staff are also afraid of being cast in the slacker role so they’re unlikely to ask for help from their busy coworkers even if they need it, and more to the point, even if their clients would benefit from it.

4) Our programs are generally set up with professional differentiation. Each profession values their particular skills and identity. They tend to have their own treatment schemas, languages, processes, and goals. For someone to be qualified to supervise their work properly the supervisor needs to be of the same profession as the supervisee. Therefore, teammates usually are not accountable to their team leader as much as to their professional supervisor which can badly weaken the team itself. There is a large resistance to altering this structure because it feels like a direct attack on the professions themselves and the inherent value professional roles bring to staff.

5) It may be difficult for staff with substantially different educations, salaries, and experience to act as “classless” teammates. Often internal hierarchies will be formed

with some staff expected other, “lower” staff to work for them. There’s a classic definition of teamwork as “a group of people doing what I tell them to” that captures this issue.

A FSP is likely to incorporate four groups of people into its teams who have not often been teamed together before: Psychiatrists, paraprofessionals, consumer and family member staff, and licensed clinicians. Each of these groups brings their own gifts that would be missed without them and each brings their own challenges.

### **Psychiatrists:**

The time when psychiatrists were fully included on teams in CMHCs, including many in leadership positions, is long past. While decreasing the number of and roles for psychiatrists may have been initially driven by cost cutting concerns, we are now at the point where there often aren’t enough psychiatrists available even if funding were to be allocated. Psychiatrists have been so consistently relegated to isolated, highly reductionistic, exclusively medication oriented roles that there is very little desire to increase their roles or belief they would contribute substantially if they were more included.

The most obvious advantage of including psychiatrists would be to increase the probability of engaging people with medications. People are more likely to take medications if they have a good relationship with the psychiatrist or if another staff they have a strong relationship with accompanies them to their medication appointments. Since FSPs are designed to target poorly engaged people and they’re designed to continue to work with people when they miss appointments and stop medications, instead of just discharging them, this is an important concern.

The most obvious challenge to including psychiatrists is professional differentiation. It is difficult for psychiatrists to be comfortably supervised by non-psychiatrists and there is a tendency for psychiatrists to expect to automatically be at the top of the hierarchy like other physicians rather than be true colleagues. The relationship between the team leader and the psychiatrist is crucial.

Beyond those issues, however, are other challenges unique to psychiatrists. First is the high caseload expectation. It is difficult for any person to keep track of more than 150 people’s stories and relationships in their head. Every other staff routinely has a caseload less than 150 whereas almost every community psychiatrist has a caseload larger than 150. The two most common ways of dealing with this are for psychiatrists to focus their attention very narrowly on the illness part of the person and to use the chart as a memory crutch. Both of these widespread practices are likely to be harmful to the people being served. In addition, trust is usually based not on an actual relationship between the two people, but based on the doctor role itself: “Trust me. I’m a doctor.” A well functioning team can serve as a memory and relationship extender for the psychiatrist and promote real trust.

Second, is the difficulty differentiating between symptoms and feelings. If a psychiatrist only gets to know, and only writes down to remember, features of the illness, they are

more likely to diagnose feelings as symptoms and treat them with medications instead of addressing emotional or life circumstance issues. Many people find it easier to take a pill than to make emotional or life changes and willingly collude in a “medication only” treatment plan. Unfortunately, it’s only rarely really successful. For people not willing to collude in labeling feelings as symptoms, we often accuse them of lacking insight and being noncompliant and the psychiatrist simply doesn’t know the person well enough to offer what they want. A well functioning team can assist with the information needed to make differentiations and assist in helping people work on their lives.

Third, psychiatrists routinely have ultimate legal and medical responsibility for people even if they don’t know them very well. This is likely to lead to caution, self protection and risk avoidance. Decisions ranging from involuntary hospitalization to employment to child custody to becoming your own payee are likely to be effected. Usually this protective bias hinders recovery. The team can make more group decisions and share responsibility. In crisis situations every team has an emotional core person they can turn to. If this person is not the psychiatrist, there may be a conflict between emotional cohesion and following the psychiatrist’s medical orders. Who does the team really trust and whose decisions get implemented may be different people.

### **Paraprofessionals:**

There is a substantial resistance to hiring more paraprofessionals instead of more licensed clinicians. Hiring people with “just” Bachelor’s degrees or “life experience” feels to many professionals like we’re “dumbing down” our staff. They argue that since we’re focusing on people with very serious, persistent mental illnesses we need the most clinical training and expertise we can get in our staff.

Within medical model paraprofessionals have serious liabilities. They don’t know how to do diagnostic assessments. They have limited understandings of psychopathology and psychodynamics. They can only bill for certain services and often need the licensed staff to cosign their notes. At best, they are likely to be viewed as helpful underlings or “go-fers.”

Within a recovery model paraprofessionals serve two crucial roles: Generalist “case workers” and specialist support service providers.

Whether they’re called case workers or community workers or personal service coordinators, their two main functions are engagement and coordination/training. Being able to engage someone is sometimes a clinical skill, but more often it’s a personal skill. Staff must be able to accept people who would normally be rejected, open their heart to people, and have a willingness to connect with people instead of distance themselves from them. It’s easier to create a true counterculture of acceptance when paraprofessionals are included to increase hiring choices and staff diversity. Less experienced staff may need help from more experienced staff to preserve their emotional strength and maintain strong ethics without distancing and dehumanizing. Coordination/training often requires going into the community doing things alongside people while teaching them how to do it themselves. People may need help coordinating an enormous range of things from grocery shopping to Social Security benefits to

employment interviews to their love life. Many licensed staff are reluctant to perform these services because it's not what they were trained to do or because it's unprofessional or even because they're just not very good at it. Engagement and coordination/training are not "lesser" services. They are core recovery services.

A FSP should include a variety of specialist support services like housing, employment, education, substance abuse, community integration, money management, and family support. These jobs require a high level of specialized skills which are not often taught in the usual professional training programs. Staff will usually have learned these skills through life experience or on the job training. It is usually not very effective to have staff without these specialized skills try to do these jobs even if they have other professional training. There is a choice of whether to have these staff included as full team members or as attached specialists. There is also a choice of whether to have these staff relate primarily to clients or to the community.

### **Consumers and Family Members:**

A program may have consumers and family members hired as peer advocates or as consumer and family representatives to insure inclusion of consumer and family perspectives or to provide peer support services, but those are unlikely to be full FSP team members. FSP team members will likely have the same generalist and specialist roles as other paraprofessional team members.

When consumers and family members are included in the team there is a choice whether to have them work in designated consumer and family positions or as paraprofessionals. There are substantial risks involved in making designated consumer and family positions. They may be treated as second class employees rather than as equal teammates. There is a risk of low expectations and other staff caretaking them. If instead, they are treated the same as any paraprofessional staff (or even professional staff if they have professional training) they will break down the "us vs. them" boundaries and we will all become less stigmatizing. They should be hired, not out of pity for their disabilities or struggles, but out of respect for the added strengths and skill sets their "life experiences" have given them. The relevant qualification is not a documented diagnosis or open case in treatment, but rather the ability to use past experiences and self disclosure to help people. As with any person with a disability, they may need accommodations to perform their job, but they shouldn't have lower job expectations or demands. Consider how differently we treat a blind colleague than a mentally ill colleague. Consumer or family status is not an excuse for substandard work.

It may be helpful to have a consumer or family member mental health worker training program to increase the qualifications of new consumer or family staff. Some of this can be combined with other paraprofessional training programs or on the job orientation and training, and some can be separated out, especially for unique "consumer" or "family" issues (e.g. self disclosure, changing self identity and roles, Social Security benefit changes, and not expecting everyone to need the same things that helped them.) Special attention should be paid to helping consumer and family staff not reenact their own harmful treatment experiences as either victim or perpetrator. Programs may want to have volunteer, transitional employment, or training positions for consumers or families

to prepare them to be staff (permanent staff who are identified consumers or family members can contribute unique supervision and support), but overlap between people's treatment providers and their mental health employment may create substantial problems. Therefore, the more separation between the two sites the better. Treatment providers are encouraged to advocate for, coach, and support the people they are serving who are working in mental health, just as they would any employment, but hiring of consumers or their families by the same team that is serving them should be limited to temporary engagement, exposure, or training positions. Permanent employment should be separated. Once they are hired as permanent staff, it's preferable to treat them as responsible equals.

Staff who have mental illnesses themselves or who have family members with mental illnesses may freely chose whether to disclose that information universally, selectively, or not at all. Although there are clear benefits for the people being served from staff disclosure including increasing hope and decreasing stigma and the walls between us, disclosure is entirely a personal decision. Staff should not be pressured to disclose. In addition, supervisors and co-staff should not discriminate against or hinder someone because they have disclosed and acknowledged their role as mentally ill consumer or family member. They must be treated with respect as a colleague. Demeaning them or creating a hostile work place for them should not be tolerated.

### **Licensed Clinicians:**

Although many licensed clinicians admire and are touched by the goals and values of the recovery movement, most will also perceive it as a clear threat to their way of life. The role of therapy seems to be being transformed from one of our most essential, mission defining services (perhaps second only to medications) to a vague activity to be incorporated into other services. Many therapists may resent being asked to be therapeutic outside of the usual parameters of office based individual and group therapy and being asked to work in ways that are often contrary to what they were taught. A range of fears, including physical and emotional danger, ethical concerns, malpractice claims, inability to bill productivity, and loss of effectiveness are likely to emerge. Although standard therapy formats may have limited effectiveness and be unusable by many of the people we serve, they are comfortable to therapists and feel safe. They are also what they have been trained to do, have mastered, enjoy doing, and value. Therapy has been internalized into their identities: "We are therapists. What will happen to us if therapy isn't what we do?" A true personal transformation is being forced upon them.

Transformation requires three steps: breaking down, adding new features, and reforming.

Step 1: Breaking down involves looking within the practice to find the values and functions. Staff came to the various licensed professions for a variety of reasons, trying to accomplish a variety of things, and found away to be fulfilled and of service within therapy structures. Therapy structures may not be essential for fulfillment and service, but they are how they're commonly achieved in our present system.

What functions actually require regular, individual or group, appointment based structures? Many "targeted," "manualized" therapies claim they do (for example,

EMDR, CBT, DBT, behavioral desensitization, trauma groups, skill building, and psychoeducation). To be fair though, most experienced therapists don't practice "manualized" therapies. They've made adaptations to the techniques, pick and chose what fits their personal styles, and incorporate them into a more "eclectic" long term, supportive therapy structure. Transference based psychodynamic therapy, for example, has evolved to depend more on training people to be conscious of their psychodynamic patterns and making interpretations than on creating and resolving true transference regressions. Recovery isn't asking for the abandonment of these techniques, but it is asking for new adaptations, picking and choosing, and incorporation into an "adult-to-adult," "friend-like," case management relationship.

Most therapists are able to safely and comfortably have a variety of fulfilling, helpful friendships outside the therapy structure. Therefore, at least theoretically, what recovery is asking for is possible. Friendships, like recovery relationships, aren't relationships without boundaries. They have different boundaries than therapy structured relationships that are often uniquely developed depending on the person.

Step 2: We're adding two new features: 1) Instead of using long term, supportive therapy as the underlying, relationship maintaining matrix to incorporate our therapeutic techniques, we're using the same engagement and coordination/training the paraprofessionals are doing. This helps us achieve a variety of quality of life goals and help people build community based skills and supports while achieving therapeutic goals and healing. 2) We're being flexible enough to maintain relationships with people who would normally drop out of appointment based individual or group therapy and be lost to us or require coercion to re-engage.

Step 3: We're reforming a new "therapy – case management" role. Then we can address all those fears (including physical and emotional danger, ethical concerns, malpractice claims, inability to bill productivity, and loss of effectiveness) within our transformed roles and create new protections and comforts while preserving the old fulfillments and values.

Licensed clinicians have to perform a variety of tasks to keep the entire team functioning. They are usually responsible for doing intake assessments and triage. They have to oversee treatment planning authorization and documentation. Often, though not necessarily, they are the administrative and emotional leaders of the team. They may have supervision, treatment modeling, and teaching responsibilities as well.

They also have a responsibility to create a "therapeutic milieu." In the not terribly distant past, there used to be something called "milieu therapy" that was included in almost everyone's treatment plan. The idea was that the staff, in addition to performing individual services, together created a healing environment for the people being served. Under pressure from budget accountability, medical reductionism, high case loads, risk avoidance, poor building maintenance, and even professionalization "therapeutic milieus" have almost disappeared from our community clinics. Most simply do not have a very welcoming or healing feel to them.

FSPs, because of their flexibility to accommodate drop-ins and because of the intensity of services and relationships can create internal healing cultures – like a group therapy without any set hours – that aren’t generally possible in standard outpatient settings. Licensed clinicians can bring special skills to help create a healing environment. Some of this work is done directly by being part of the environment (for example, by helping to maintain relationships with difficult people, providing “corrective emotional experiences,” and training people to be conscious of their psychodynamic patterns and making interpretations) and some of this work is done indirect by supporting teammates (for example, by consulting and educating, sharing countertransference reactions, building team cohesiveness and emotional strength).

Like the paraprofessionals, many of the licensed staff will bring specialist skills and services (for example, medication management, health care, crisis management, specialized assessments, community advocacy and development, and rehabilitation) that can be accessed by all the people on the team.

**FSP Staffing Patterns:**

When we’ve put together all these ideas, we’ve found that the overall “staff items” making up the teams have changed. Compare these two sample 100 member FSP staffing patterns.

<b>“Traditional-Clinical” FSP team</b>	<b>“Recovery-Based” FSP team</b>
1 Psychiatrist	1 Psychiatrist
1 Supervising Social Worker	1 Team Leader (Supervising SW, psychologist or MHRN)
3 Psychiatric Social Workers	1 Psychiatric Social Worker or 1 RN (depending on leader)
1 Mental Health Counselor RN	1 Psych Tech or nurse aid
1 Psychologist	5 Case Managers (may be consumers, case workers, or community workers)
2 Medical Case Workers (one housing, one employment)	1 Housing specialist
2 Peer Advocates	1 Employment Specialist
	1 Benefits Worker/ Financial Planner
	2 Outreach workers (one licensed, one consumer, case worker, or Community worker)

(Both teams cost about the same \$900,000.)

Notice the following differences:

- 1) We’ve define our recovery-based staffing pattern by roles rather than by allocated quotas for each profession. This is especially relevant for jobs that aren’t really taught in

any professional school (e.g. team leader, housing specialist, employment specialist, and outreach worker). Hiring by profession could easily get you stuck without the needed skills. Incidentally, the State MHSA workforce Development Committee has already taken the approach of looking at function instead of profession too.

2) Consumers are integrated into the team, hired because of their skills, rather than as segregated, potentially second class employees.

3) Because of cost savings by decreasing licensed personnel three additional staff could be hired. That dramatically decreases the case loads. For example, if you decide that the team leader, psychiatrist, housing specialist, and employment specialist don't have case loads, but the nursing staff, financial planners, and outreach workers do, and that this team has 100 members, the "traditional-clinical" caseloads would be 14 and "recovery-based" caseloads would be 10. Another way to look at that is that the "recovery-based" team could have a specialized financial planner and half case loads for the nurses and the two outreach workers and still have the same caseload as the "traditional-clinical" team.

Implementing FSP teams with staffing patterns like those on the "recovery-based" side of the table will present substantial challenges to Human Resource Departments creating job descriptions and to Unions advocating for their professional guilds.

As I reread this paper, part of me feels somewhat overwhelmed by all the changes we are asking people to make, but part of me also feels excited by the prospect of being able to help a lot of people who have fallen between the cracks. For me, that's what this transformation is all about.

## **Hiring and Supporting Consumer Staff**

By Mark Ragins, MD

I once wrote that I thought that the single most transforming thing the mental health system could do would be to hire large numbers of consumer staff. Now, because of the Mental Health Services Act counties all over the state are doing just that. I wrote that because I believe that hiring consumer staff will have an enormous anti-stigma effect challenging the prevailing image of people with mental illnesses as incompetent, irresponsible, and dangerous.

Consumers who are willing to disclose their experiences with mental illnesses hired in any position will have opportunities to reduce stigma in a variety of ways. Broadly speaking stigma reduction can be directed towards 1) the people we serve and their families (for example by being a successful role model), 2) mental health staff and administration (for example by changing staff's perceptions of the abilities of people with mental illnesses by working alongside them as their colleagues or by "vetting" policies and practice guidelines from a consumer perspective), and 3) our community (for example by promoting social networks that welcome people with mental illnesses through self disclosure or promoting more positive media coverage of mental illness by publicly disclosing personal experiences with mental illness).

However, we must be careful as we move forwards. Potential pitfalls seem to be everywhere. It seems to me that the foremost risk is that if our consumer staff work poorly the stereotypes will be reinforced rather than challenged. If we include consumers in our clinics in only limited protected roles and the professional staff have to heavily support them and give them lots of accommodations we risk reinforcing staff's negative expectations. If we create independent consumer run programs that are poorly run, aren't held accountable, have violent incidents, and turn to the local clinic for help in crises we risk reinforcing our communities' fears.

When the Village first began we hired a few of our "best" members to work answering the phones and making lunches for homeless people. They worked three hours a week in stipend jobs making \$65 per month so their SSI checks wouldn't be affected. They mostly did their jobs poorly and we were "understanding." When Paul Barry came to us from Corporate Cookie, a busy cookie store on Wilshire Blvd. run by people with mental illnesses, he said that we weren't going to have any more little stipend jobs. All jobs would be five days a week, two to four hours a day, and furthermore, all work would have to be done at community standards. I said that was the stupidest idea I'd ever heard. Didn't he understand that these people had serious mental illnesses? They're disabled. They couldn't even do the stipend jobs well.

Since the psychiatrist doesn't run the employment program at the Village we did it Paul's way. Sure enough, he ended up firing most of them. But before I could get up to his office to say, "I told you so!" the strangest thing happened. Most of them wanted to try to get their jobs back and I was too busy working with them figuring out what had gone wrong and helping them change it. We changed medications, created new support plans, even worked on stopping drugs and alcohol, so they could succeed. And Paul fired most of them again.

By the sixth or seventh time, however, they were starting to really get it. The vast majority of people who did stipend jobs poorly could develop enough to do daily jobs at community standards. Paul called it “work hardening.” I called it frustrating. Ultimately, he was right. Our kindly low expectations weren’t helping them grow and work effectively.

If everybody has to learn that lesson the hard way like I did, we may be in trouble.

We’re not hiring people with mental illness not out of pity for their disabilities, or out of compassion for their struggles, but out of respect for the added strengths and skill sets their experiences have given them. We’re hiring them because they can work effectively, often in ways we can’t, and because if they’re successful it’ll break down stigma and transform all of us.

We’ve already run into difficulties in almost every county with human resource departments mostly because of civil service rules prohibiting affirmative action. Even building in a preference for hiring people with mental illnesses into job descriptions has been elusive. Most counties have reacted by either creating special Peer Advocate or Peer Supporter jobs or by contracting out consumer employment entirely. Both of these approaches widen the distance between consumer staff and “normal” staff decreasing the likelihood of lowering boundaries and stigma and risk creating segregated “separate but equal” arrangements. Unless some arrangement is made for consumers to be integrated as full colleagues we’re unlikely to really succeed.

It’s scary for staff to really accept people with mental illnesses as colleagues. And to be fair, it’s scary for some consumers to give up their “protected” consumer jobs to be integrated. We’re hardly on solid ground for heavy advocacy to human resource administrators who often have other more pressing interests than fighting stigma. To advocate from a position of strength, we need to begin with what employment roles consumer staff will add to our services.

The relevant qualification is not a documented diagnosis or open case in treatment, but rather the ability to use past experiences and self disclosure to help people. We need to be specific about how we expect them to use those experiences (and equally importantly, deal with fears about how they shouldn’t be using those experiences). What are the roles consumers can perform that other people can’t?

**1) Consumer representative** – Consumers should be included in all levels of decision making, planning, and program design embracing the spirit of “nothing about us without us.” Representatives must be careful to present not just their personal positions, or even just those positions sanctioned by the “consumer movement” and their established organizations. They are responsible for presenting the range of positions of the effected consumers carefully including those unable to articulately speak for themselves.

**2) Peer advocate** – Peer advocates work to help improve the system on behalf of individual consumers. This must be a collaborative arrangement where the peer advocate’s agenda clearly represents the choices of the consumer they are representing,

rather than the advocate's agenda, since they are the ones who will experience the consequences of the advocacy effort, both good and bad, most directly.

**3) Peer supporter** – Peer supporters rely on listening to people's stories and sharing their own stories to support individual consumers. Care must be taken to emphasize shared personhood rather than shared patienthood even when sharing experiences directly related to illnesses and their symptoms. An important function of peer supporters is to reduce the possible stigma and personal damage of the diagnostic labeling process by sharing and thereby normalizing people's experiences. The goal of peer support is not to give advice through the shared stories, but to strengthen the person being supported by creating a feeling of being understood, educating them, broadening their awareness, opening up new opportunities, and increasing their sense of hope, personal power and self-responsibility. Peer supporters will likely benefit from the sharing process as well, but must make sure that meeting the other person's needs take precedence over meeting their own needs.

**4) Peer bridger** - Peer bridgers may act as a bridge into mental health services outreaching and engaging with people who are not collaborating voluntarily with mental health services. Peer bridgers may also act as a bridge to community connections for people by helping people begin to move beyond strictly professional support, by using themselves as positive role models of people using community supports, and by opening up new opportunities in our community for people with mental illnesses by sharing their stories within the community.

**5) Peer counselor and peer case manager** – These people provide the same range of case management and community support services as their non-mentally ill colleagues while emphasizing the strengths of their shared experiences, for example promoting engagement, risk taking, empowerment, self-responsibility, acceptance, independence, and graduation. It is expected that these staff's effectiveness would benefit from a decreased perception of power differential and less professional distance.

**6) Peer self-help facilitator** – Consumers may be facilitators of self-help groups and programs either volunteer or paid. Then they are required to maintain staff responsibilities and ethics. (For example, they may no longer date or have financial dealings with other group members.) Some people's responsibilities will change within the same group when they are hired or leave employment in that program. It is possible to be a participant in one group or program and a staff in another one.

The bottom line is that none of these roles can be accomplished unless consumers are hired. That's solid ground to approach administration with. It's devoid of pity, compassion, or affirmative action.

Each of these roles do not necessarily define job titles or the person's professional identity. They all may be integrated into our "normal" job descriptions. Each requires specific skill sets beyond experience with mental illness that can be included as "additional qualifications."

Our next challenge is to properly prepare and support consumer staff so they'll actually succeed. There's two basic parts of this task: Job training and personal support. There's also a need to have training and support available throughout the entire process from recruitment to leadership promotion. Here's a table of what's needed:

<b>Function</b>	<b>Content</b>
Engagement	Identifying consumers and families in clinics – engaging with clients interested in MH employment  Consumer advisory boards  Volunteer assignments and mentoring at their clinic  Inclusion in Wellness activities / Self-help programs  Inclusion in clinic planning, education, and operations
Job Training	Build on existing curriculums  Add needed skills <ul style="list-style-type: none"> <li>• Case management</li> <li>• Recovery relationships</li> <li>• Clinic / program operations</li> <li>• Billing</li> <li>• Self help groups</li> </ul> Specific content for each role  Specific content for each clinic / program
Transitional Support/ Role Training	Consumer issues <ul style="list-style-type: none"> <li>• Disclosure</li> <li>• Peer roles</li> <li>• Consumer movement and advocacy (OCA)</li> <li>• Personal role changes</li> <li>• Benefits effects</li> <li>• Moving clinical care</li> </ul> Includes Support Group
Hiring	Job descriptions Job qualifications Approving job candidates Local interviewing and hiring
Orientation	Systematized orientation for all staff Assign onsite clinic supervisor and peer mentor Shadowing variety of staff to be exposed to all clinic functions

On Job Supervision	<p>Job expectations and performance evaluations</p> <p>Extra onsite training if needed</p> <p>Mentoring for supervisors (supervisor group to share problem solving)</p>
On Job Support	<p>Consumer Issues focus</p> <ul style="list-style-type: none"> <li>• Boundary issues</li> <li>• Confidence</li> <li>• Fear of losing benefits</li> <li>• Acceptance</li> </ul> <p>Peer Mentors onsite</p> <p>Ongoing Support Group</p> <p>Accommodations</p> <ul style="list-style-type: none"> <li>• Utilizing a job coach</li> <li>• Providing additional individualized training.</li> <li>• Designating a co-worker as peer support.</li> <li>• Benefits counseling</li> <li>• Flexible Scheduling</li> <li>• Job sharing</li> <li>• Allowing workers to shift hours for appointments</li> <li>• Leave during a hospitalization</li> </ul> <p>Train team staff to be able to include and support consumer staff</p> <ul style="list-style-type: none"> <li>• Confidentiality</li> <li>• Role confusion</li> <li>• Inclusion</li> <li>• Supervision</li> </ul>
Transition to integrated employment (non-consumer restricted jobs)	<p>Additional training and HR policies to transition to paraprofessional jobs</p> <ul style="list-style-type: none"> <li>• Administrative Assistant</li> <li>• Job Coach</li> <li>• Housing developer</li> <li>• Community support worker</li> <li>• Program Manager</li> <li>• Case Manager</li> <li>• Case Manager Assistant</li> </ul> <p>Supervision to full staff responsibility</p> <p>Support for professional training to transition to professional jobs</p> <p>Career ladders</p> <p>Leadership training and mentoring</p>

I don't think we'll have much disagreement over the items in this list. (Although there may be substantial arguments over who has the expertise and authority to provide these trainings and supports. In particular, which of them "must" be provided by consumers can be a thorny issue.) I expect the problem will be having the will to actually create all those items. It's easy to look at a table like that and say, "All that would be nice, but we don't have the resources, and it would take too much time to set up, and we don't have anything like that for our 'normal' staff, and we need to get started now...so let's just hire a few consumer staff now and see how it goes."

The further we go along with hiring and supporting consumers, as with most of this transformation effort, the more detailed and complex everything gets, but also the more plausible it seems.

One final counterpoint before I close: What about family members? Both the President's Commission Report and the MHSA routinely lump "consumers and their families" together and yet their fates seem to be playing out very differently. Families have been effectively involved in the planning process, but rarely included in direct service delivery or mental health employment. We see large numbers of consumers almost everywhere wanting jobs in mental health to "give back," but very few family members. There's probably a wide array of reasons for this, but at least for now families aren't being employed and it isn't high on anyone's advocacy agenda to do anything about it. Should it be?

## **New Rules for Staff to Work By**

By Mark Ragins, MD

As I travel around the state conducting recovery based transformation workshops, I'm inevitably faced with an objection from the back of the room, "What you're telling us to do is against the rules. I'd get in trouble with my supervisor for that." Indeed when I looked at the personnel policies for Los Angeles' DMH, I realized I break a dozen rules before lunch. I am an outlaw.

Although it would ultimately involve sitting hour after hour in a workgroup debating every last word, I realized we'd have to rewrite the "rules" if transformation was going to have a chance. We have to bring our policies in line with a recovery based practice if we expect to succeed.

This document is the product of Chad Costello, David Pilon, and me from MHA joining a DMH Medical Director's work group including representation from unions, risk management, human resources, and the Office of Consumer Affairs. This is our final draft. It has to go through several more layers of administrative approval to become official. Nonetheless, I've included it in this set of papers in the hopes it will help guide others as you rewrite your rules.

No one told me when I was sitting in a college dorm room dreaming of changing the world, that to do that you have to sit in long administrative meetings writing beaucroatic parameters, but here they are.

**4.12 PARAMETERS FOR SERVICE RELATIONSHIPS IN A RECOVERY-BASED MENTAL HEALTH SYSTEM**

7-26-06

**I. INTRODUCTION**

The Department of Mental Health (DMH) has adopted concepts of the Recovery Model for the transformation of its delivery of mental health services. For the purposes of these parameters, recovery refers to both the process individuals go through as they rebuild their lives and to the mental health treatment movement focused on promoting individuals' recoveries. It includes an underlying belief that every individual can recover substantially, if not entirely, and deserves support to achieve their recovery. Although recovery is a uniquely individual process, each individual's progress can be described and tracked using a variety of descriptive tools. Generally this progress is conceptualized as moving through a series of stages, for example, hope, empowerment, self-responsibility, and attaining meaningful roles. These stages are flexible and fluid. They are fundamentally the same stages all individuals progress through as they recover from serious setbacks.

In adopting this model, DMH recognizes the role effective relationships between our staff (which includes volunteers and contract personnel) and the individuals we serve (individual) will play to accompany them through the stages of recovery. Staff must develop and use all their skill, education and talents to create and maintain caring, positive, and supportive relationships with individuals. DMH also recognizes that there may be new, substantial and complex risks inherent in such relationships.

**II. PURPOSE:** DMH has created these parameters to:

1. Support staff to manage potential risks successfully;
2. Serve as guidelines to understand recovery model concepts and the relationships essential to assist an individual through the stages of recovery successfully;
3. Clarify standard processes in the event of future legal actions,
4. Avoid misunderstandings for staff and individuals who may be unfamiliar with Recovery Model concepts;
5. Become aware of needs for staff training and performance improvement;
6. State the department's written intentions as a resource and training tool for staff, managers and individuals; and
7. Improve morale by establishing an opportunity for individuals and staff to participate in and review the parameters as they currently exist and may evolve.

**III. RELATIONSHIP TO EXISTING POLICY OR REGULATIONS:**

These parameters are not to be considered as a substitute for compliance with relevant existing Departmental or Agency Policies and Procedures (P&P,) Codes of Ethics and Conduct from individual licensing boards or regulations. Relevant Departmental or Agency policies include but are not limited to:

1. Ethics (See DMH P&P 100.1. Department of Mental Health Code of Ethics)
2. Compliance Policies and Programs (See DMH P&P 112.2 Compliance Program)

3. The Health Information Portability and Accountability Act (HIPPA) (See DMH P&P 500.1 to 500.10 HIPAA)
4. Sexual Harassment Prevention (See DMH P&P 605.2 Sexual Harassment Prevention-Anti-Retaliation)
5. Conflict of Interest (See DMH P&P 608.2 Conflict of Interest)
6. Organizational Codes of Conduct (See DMH Code of Organizational Conduct)
7. Illness and Injury Prevention Programs (See DMH Illness & Injury Prevention Program)

#### **IV. PERTINENT RECOVERY MODEL CONCEPTS AND COMPONENTS**

1. Creating and Establishing a Recovery Milieu
2. Engagement and Understanding
3. Emotional Healing
4. Financial and Work Relationships
5. Medication Support
6. Psychosocial Rehabilitation
7. Substance Use and Abuse
8. Working in the Community
9. Working with Law Enforcement

#### **V. PARAMETERS ESSENTIAL TO THE UNDERSTANDING AND DEVELOPMENT OF SERVICE RELATIONSHIPS IN A RECOVERY MODEL.**

##### **1. Creating and Establishing a Recovery Milieu**

Individuals need a safe place to recover. This safe place must provide acceptance, understanding, hope, emotional and practical support, treatment and rehabilitation. It must also provide a base for increasing self-responsibility and achieving meaningful roles in the community. DMH expects all staff to work together to insure every program is a safe place in which recovery can occur.

- A. Creating a recovery milieu depends upon all staff, including clinical and non-clinical, creating caring, positive, and supportive relationships with everyone they meet, whether they are on their caseload or not. This creates a web of recovery-based relationships that serve as a powerful environment for all our services and protects both staff and individuals
- B. Program supervisors are responsible for creating and maintaining the recovery milieu in their program. Their leadership should emphasize hope, healthy usage of authority, healing, and community integration. Staff should contribute positively in each of these areas.

##### **2. Engagement and Understanding**

Staff are expected to develop enough trust with an individual to be able to engage them in treatment and understand both their mental illnesses and them as individuals.

- A. Trust-building should rely on shared humanity in addition to emphasizing professional authority and expertise. Toward this end, staff are encouraged to use:

- 1) therapeutic self-disclosure,

- 2) agency charity, i.e. the giving of resources to individuals to improve their lives without requiring them to do anything in return. Examples of agency charity include providing bus tokens, food, or clothing,
  - 3) “meeting individuals where they are” for example in terms of dress, in order to emphasize attempts to decrease the distance between us,
  - 4) language, cultural competency and spiritual sensitivity, and
  - 5) using personal connections to individuals or places in the individual’s life to enhance the original engagement and ongoing relationship. Examples of these connections may include circumstances in which you may already know the person or someone in their family, or have some shared interest or history, e.g. you went to the same high school or came from the same state.
- B. Staff should be careful not to take advantage of this trust by taking over decision-making for an individual. Staff should instead focus on building a collaborative relationship by giving an individual choices and meaningful education about those choices.
- C. When an individual shares their story with staff they place themselves in a vulnerable position. It is imperative that staff protect their story. Staff must respect confidentiality rights and keep information within the confines of the mental health system. However, personal confidentiality or exclusivity between an individual and a staff member is not a right and should be used cautiously and circumspectly. Keeping personal secrets may increase the risk of fragmented care, personal impropriety, and even danger, along with possible losses of staff accountability, documentation, and funding. Staff are expected to work as an integrated part of the entire mental health system, not as an individual practitioner.

### **3. Emotional Healing**

One of the primary goals of mental health services is emotional healing. Individuals with mental illnesses often have substantial emotional distress. This distress can arise as a part of their illness, as a consequence of their illness, for example, stigma or the services received, or from other issues in their lives. Emotional healing can be either the direct reduction of the state of emotional distress or the improvement of underlying emotional traits that contribute to ongoing emotional distress.

At our most effective, our services should go beyond impersonal assessment, medication, case management, and placement to incorporate emotional healing. In general, to be healing requires skillful maintenance of relationships of substantial emotional depth. Traditionally, these relationships have been contained and protected within the controlled confines of therapy sessions. Staff are now expected to integrate healing throughout a variety of roles and settings.

**A.** High levels of personal emotional strength and awareness are a basis for the effective and safe promotion of emotional healing in others.

- 1) Staff may find themselves challenged by tragedies and traumas, both to an individual and to themselves. At these times, staff should make every possible effort to reestablish their emotional strength and seek personal healing. Both supervisors and team mates have a responsibility to ensure that all staff have personal and professional support in this effort. Supervisors are expected to help staff utilize all internal and external resources at their disposal.

- 2) Staff should not tolerate being abused, threatened, taken advantage of, or harmed sexually, emotionally or physically by an individual. Supervisors and teammates must act purposefully to protect staff and report such actions to their supervisors.
- B. Staff may not demean, emotionally abuse, intentionally wound, or be physically aggressive or threatening to an individual regardless of the circumstances. The risk of these infractions should be reduced by staff knowing their own emotions. Staff can be clearer about the emotions involved by avoiding treating those individuals with whom they have previous or ongoing personal relationships. Supervisors and teammates must act purposefully to protect individuals and report such actions to the manager.
- C. Physical contact between staff and an individual may often contribute to emotional healing, but it carries special risks. Staff absolutely must avoid all inappropriate touching or other sexual contact with an individual. Sexual attraction or “falling in love” by either the staff or an individual dramatically increases the risk of inappropriate and/or unethical behavior on the part of staff. Therefore, these emotions must not be kept private. When confronted with these situations, staff must make their supervisor and teammates aware of them. Therefore, situations in which there is likely potential for inappropriate behavior or allegations of inappropriate behavior, staff should discuss the situation with teammates and with their supervisor. Supervisors shall report these situations immediately to the program manager. The program manager, upon evaluation of the situation, should report when warranted to the DMH Human Resources Bureau (HRB) for possible reporting to the Los Angeles County Office of Affirmative Action Compliance. Decisions regarding further contact between the staff and the individual shall be based upon a consultation with the Manager and DMH HRB.
- D. Persons with mental illnesses are valued by DMH in all staff positions because their life experiences afford them unique abilities to engage with, understand, and emotionally heal an individual. They must meet the same employment standards as staff without mental illnesses.

#### **4. Financial and Work Relationships**

Treating mental illness should focus on improving quality of life. As a result, mental health services include a wide range of social activities managing an individual’s money, using discretionary mental health funds, and assisting individuals in accessing other funds to improve their quality of life.

Staff control over financial and other resources creates a potentially problematic power differential between staff and an individual. Even when staff believe that they are acting in the best interests of an individual, there are risks of exploitation, withholding, and manipulation.

- A. These risks shall be reduced by establishment and adherence to clear policies, sharing decisions with supervisors and teammates, having clear paths for an individual to air grievances, and by the keeping of transparent and accessible records.
- B. Staff may not get involved in personal financial dealings, e.g. the personal exchange of goods or services with an individual. Staff may not use a program participant’s funds, discretionary mental health money or other program related funds for their own use.
- C. Staff who are serving as a representative payees are at particularly high risk for the development of a power differential and therefore may require additional physical

protection. The same staff who is serving as a payee for an individual should not also have primary service coordination or emotional healing responsibilities for that same individual. Payees may use physical barriers for additional protection when needed, especially when handling cash. Payees should be in physical proximity of other staff and/or security staff when handling cash and interacting with an individual. Representative payee policies should include procedures for handling cash.

- D. With the approval of the manager, staff may operate in the role of “work supervisor” with an individual. These work experience, day labor, life coach, and peer supportive services jobs should all be temporary, part-time positions designed to promote an individual’s growth while they perform needed work. Staff must be conscious of the additional risks inherent in these more complex relationships, and should make it clear to an individual that the true employer is the organization and not the staff person. Fulltime, permanent jobs should be separate from an individual’s treatment team.

## **5. Medication Collaboration and Support**

Although taking medications is not a prerequisite for an individual to receive services, medications are an important factor in recovery for many people. Medication collaboration is the process where the prescribing professional and an individual taking the medications work together to find ways of using medications that will benefit the individual. This is in contrast to a definition of medication compliance in which the prescribing professional orders the individual to take medications in the way they think best and an individual is expected to comply with those orders. It is expected that all staff, not just those whose scope of practice includes prescribing or monitoring medications, should be attentive to medication issues which they observe or are raised by an individual and respond within the context of the parameters that follow.

- A. Staff may assist an individual as they learn about their medications and the role medication plays in their lives. They should be able to provide competent guidance about additional credible sources of information about medication. Staff may also assist an individual to improve communication with their prescribing professional, and may use their relationship to increase medication collaboration. They may not, however, forward their own medication instructions or opinions about what an individual should do, unless their scope of practice includes medications.
- B. Staff may assist individuals in taking their medications as prescribed, for example by picking up medication(s) at the pharmacy, or helping them organize medication(s) into reminder boxes. However, they may not hand the medication(s) directly to an individual to take unless their scope of practice permits it. Examples of those with such a scope of practice would be a Medical Doctor, Registered Nurse or Licensed Psychiatric Technician.
- C. Staff may work with an individual to increase medication collaboration by a variety of means including the offering of incentives, or, with the individual’s permission, involving other individuals in their support system. However, staff may not use coercive means or otherwise withhold services or funds that may be due to an individual, except when specifically permitted by law or statute.
- D. Staff may not, directly or indirectly, give an individual medication surreptitiously, intentionally mislead or misinform them about medications, or otherwise undermine informed consent, even if they believe they would be acting in an individual’s best interests by doing so.

## **6. Psychosocial Rehabilitation:**

The practices of psychosocial rehabilitation are essential components of services that promote recovery. Psychosocial rehabilitation is a service delivery philosophy that focuses on creating meaningful roles apart from the illnesses of an individual. For staff to take on these other roles successfully, they must also take on roles apart from the illnesses. Staff may find these other roles (for example customer, coworker, and house guest) less comfortable than their usual staff roles when they are less practiced in them, but these roles are not inherently more risky. They should continue to work on therapeutic goals including emotional healing while working in these multiple roles.

Among the important staff techniques used are goal setting, motivating, skill building, and applying these skills in the community, classically expressed as the “choose, get, keep” model. They should incorporate these practices into their relationships with an individual. It is preferable to do skill building in the actual community settings where the skill will be used instead of in classroom settings.

- A.** Staff should support development of autonomy and independence in all domains, including finances, and refrain from doing things for an individual when they can do it for themselves. Encouraging individuals to provide for themselves and promoting growth are the ongoing underlying goals.
- B.** Goal setting should be value-driven and consumer-centered. Goals should reflect the choices of an individual. Goals should also reflect socially promoted values such as increased independence in housing, employment, adherence to laws, responsible child rearing, safety and others. Staff should be culturally competent, sensitive and respectful of personal choice in goal setting. However staff should not support illegal or socially destructive goals. Special sensitivity is needed when working on spiritually-oriented goals to make sure staff is truly supporting choices of an individual and not persuading them to make spiritual choices that staff may personally value. Staff may ask for another staff to work on a particular goal with an individual if it conflicts with their personal spiritual beliefs.
- C.** Motivating individuals should be based upon understanding them well enough to promote their core drives and desires rather than upon coercion. Staff should maintain supportive relationships even when an individual makes choices that may result in serious consequences. Staff should help an individual take risks in a more prepared manner and to help them learn from the consequences of their choices.

## **7. Substance Use and Abuse**

DMH is committed to serving individuals living with mental illnesses who are also using or abusing substances. Staff should be competent in the delivery of integrated substance abuse services (Co-occurring Disorders (COD) appropriate to their roles.

- A.** To effectively serve individuals with both mental health and substance abuse conditions, staff must have the ability to provide services for each condition separately, the ability to integrate services for the two conditions, and the ability to provide services uniquely designed for dually diagnosed individuals. Staff who are considered to be COD competent have these abilities in all areas of service including engagement, assessment, treatment, rehabilitation, advocacy, and recovery.

- B. Staff must maintain a willingness to actively serve individuals who are using and abusing substances, and accept them wherever they are along the continuum of recovery. However, this does not imply condoning substance use or abuse. Staff should always maintain a goal of freedom from dangerous and addictive substances no matter how remote or unlikely it appears at the time. Staff must maintain relationships and continue to serve individuals who use and abuse substances.
- C. Staff must provide or consult with their supervisor in order to arrange for the provision of a full range of substance abuse interventions appropriate to the stage of recovery of the individual being served.
- D. Staff should assume advocacy roles for individuals when dealing with other groups or agencies that have exclusionary “no tolerance” policies. In these situations staff must pay special attention to individual choice and maintain confidentiality.
- E. Program restrictions and limitations on individuals should be based on the appropriateness of their behavior, rather than on the fact that they are continuing to engage in substance use or abuse. Substance use and abuse increases the risks in relationships, including unlawful behavior, violence, and unsafe sexual practices. There may be increased risk to staff directly involved with individuals using and abusing substances. Therefore, staff should exercise extra caution and discuss any concerns with their supervisor.
- F. Staff may not use any alcohol or illegal drugs or while working, even if they are at an activity where drinking would be appropriate, and even if the individual they are serving is drinking or using drugs. Under no circumstances should staff who are impaired by drugs, legal or illegal, interact with the individuals they serve.
- G. DMH values smoking cessation and supports efforts by both staff and individuals to stop smoking. Nonetheless, both staff and individuals are permitted to smoke during work wherever permitted by law. No staff members or individuals should be in any way coerced or pressured to expose themselves to secondhand tobacco smoke, and every effort should be made to maintain smoke-free environments. However, individuals should be permitted to smoke where lawful and where others are not involuntarily exposed to secondhand smoke.

## **8. Working in the Community**

Working outside of traditional locations and in the community vastly increases staff effectiveness, but also increases a number of risks. For the purpose of these parameters, community is defined as the social, cultural and physical environment in our daily lives. This does not include treatment settings. For individuals with mental illnesses, community is the environment in which they have meaningful roles that are not solely defined by their mental illness and its treatment.

- A. Staff should serve people in the community, not just in crisis situations, but whenever it is likely to increase the effectiveness, intensity, or relevance of their service. Many times this will involve taking on friend, family, mentor, or teacher roles (for example while facilitating hosting a house warming party, attending an AA meeting with them, or attending someone’s graduation). However, staff should be mindful that their primary responsibility is not socialization or transportation alone. Depending on each person’s needs and choices, staff should be engaging, assessing, supporting charitably, emotionally healing, treating, training, rehabilitating, advocating for, or promoting

- integration into the community while working in a variety of roles. For example while going out to lunch with someone a staff may be building trust, feeding a hungry person, demonstrating caring and reliability, assessing medication side effects or functional literacy, assisting in vivo practicing of relaxation techniques, modeling social skills, introducing someone to a friendly waitress the staff knows, or working to get the restaurant to serve a strange looking person.
- B. Staff should pay special attention to confidentiality when working in the community and, within constraints of applicable laws, any disclosures should be based upon the personal choice of an individual.
    - 1) Staff should avoid identifying themselves to others as mental health workers until they have reached an agreement with an individual regarding disclosure. This may involve, for example, altering vehicles or clothing or removing identifying badges while working in the community. However, County identification badges must be carried on the person of the staff when providing services in the community.
    - 2) Staff should secure confidential documents until returned to the designated storage site.
  - C. When staff are serving an individual in the community and interacting with the individual's family, friends or other community contacts, the staff's role is not necessarily to speak for that person or take responsibility for them. Staff should be prepared to assume different roles when interacting with various agencies and individuals to facilitate attainment of meaningful roles in the community.
  - D. Staff working in the community should conceptualize their role as guide or mentor, rather than caretaker or protector of either the community or the individual. There are exceptions in emergency situations, but even when an individual is placed on an involuntary hold for treatment, relationships should follow these guidelines. Often these emergency contacts are an individual's first contact with the mental health system and therefore should be recognized and approached as important engagement opportunities.
  - E. Community work may involve unique safety risks. Staff should not work alone when legitimate safety concerns are identified. In high-risk situations, staff should consult with their supervisor and/or call for police assistance to avoid endangering themselves and others. Staff should avoid physically restraining an individual in the community.
  - F. Advocacy is a core component of recovery services. Staff are expected to fight stigma and advocate on behalf of individuals when working with other agencies and community members. Staff should expect support from their supervisors and by DMH in these efforts.

## **9. Working with Law Enforcement**

DMH is making a strong effort to serve people who are struggling to be included in our community. Many of these people also have contact with law enforcement. Staff are encouraged to become directly involved with law enforcement issues when so desired by an individual in supportive, advocacy, and collaborative roles (for example by visiting individuals in jail, collaborating with their probation officer, or providing clinical bases for sentencing determinations).

- A. Law enforcement and mental health systems have different basic missions that effect our collaborations. Mental health is primarily focused on helping individuals with mental illnesses have better lives, while law enforcement is primarily focused on increasing public safety. Sometimes these goals are in alignment, for example, when staff is trying to help someone escape a battering partner, and sometimes they are in conflict, for example, when someone staff is serving is trying to avoid criminal punishment.
- 1) In some situations, for example, the Duty to Warn or Child or Adult Protective Services situations and court ordered treatment for Mentally Disordered Offenders, mental health staff are required to act as agents of public safety and should actively support law enforcement that carries the ultimate authority and responsibility. Staff should strive to provide services collaboratively rather than under court order unless directly required for public safety.
  - 2) In some situations, for example, 5150 evaluations or involuntary treatment enforcement, law enforcement is acting as agents of mental health care and should actively support mental health staff that carry the ultimate authority and responsibility. In general, it is not law enforcement's role to directly promote or court order mental health treatment, except as it is reflected in increased public safety.
  - 3) In most situations, mental health and law enforcement are acting relatively independently. In these situations mental health staff's focus should not be on either advocating for individuals to help them avoid legal responsibility and punishment (except in situations of legal insanity, clear diminished capacity, or mental incapacity to stand trial), nor on directly assisting law enforcement's efforts to increase public safety, but on supporting individuals to meet their legal responsibilities in the most constructive way possible, so that they can be included as responsible members of our community. This includes promoting legal responsibility when individuals perpetrate crimes against the mental health staff and programs serving them.
  - 4) The above goals may, at times, run contrary to the desires of an individual. Staff should not support illegal desires, but should instead try to maintain a collaborative, emotionally healing relationship with the individual while promoting legal responsibility even during periods of disagreement or legal coercion.
- B. Because mental illness has specific legal implications there is a tendency for law enforcement to respond to the illness instead of the person. We have a responsibility to advocate for and collaborate directly to promote person-centered law enforcement responses.
- 1) When an individual with mental illness witnesses a crime or is a victim of a crime we should advocate and collaborate directly for them to be taken seriously as a member of our community with full rights.
  - 2) When an individual with mental illness is contacted by law enforcement we should advocate and collaborate directly against a presumption of increased dangerousness or irrationality unless warranted by their behavior.
- C. Law enforcement agencies may have access to specific resources and support for individuals they serve. Being a client of the mental health system should not relieve law enforcement of their responsibilities to serve individuals themselves. Mental health staff

should advocate for and collaborate directly to assist individuals in accessing these resources.

# **The Power of Flow**

By Mark Ragins MD

As we begin to build new programs with Mental Health Services Act (MHSA) funds many of us are facing the sobering realization that even in a transformed recovery based system with a good funding source it seems we'll never have enough services to help everyone in need. It seems inevitable that whatever new program we build to meet an unmet need will be filled up sooner or later and turning away new people. Is there any way out of this besides continually asking for more money? I think one way we can get unstuck would be by changing from a capacity point of view to a flow point of view. For example, the MHSA planning process asked us to look at unmet need and what services would have to be added to "meet the needs." Instead, we should look at what services could move people from "in need" to "no longer in need." Working on making this change has been the hardest thing we've ever attempted at the Village. The more we work on it the more complex it's become.

This paper will discuss six important aspects of flow that we've struggled with:

- 1) The difference between illness-centered flow and person-centered flow,
- 2) The need for services at various levels of engageability, appointment keeping, and self-responsibility,
- 3) The need for services to be growth oriented instead of care taking,
- 4) The difference between growth oriented cultures and structures,
- 5) The difficulties maintaining relationships as people grow and flow, and
- 6) The need for community integration to graduate people from professional services.

## **1) The difference between illness-centered flow and person-centered flow**

From an illness-centered point of view as long as the illness exists the need for services exists. The obvious implication is that if we focus our services, as we should, on those people with serious, persistent mental illness of indefinite duration we need to provide services of indefinite duration. This was one of the foundational principles of the Village and, similarly, the Full Service Partnerships (FSPs) have been designed to be "no fail" programs of indefinite, usually lifelong, duration. Inevitably, like the Village, the FSPs will fill up and be unable to take new people.

It is easy to see that flow and graduation is what's needed to open up new slots, but hard to see how to achieve that. We had to figure out how to alter our teams to be "transitional" programs of indefinite duration. If we could graduate some people to lower levels of service or even no service at all we'd be able take on new people.

Certainly, moving people on to lower levels of care is not a new concept, but in our normal service delivery system it hasn't worked very well. Many people keep revolving through the same services over and over instead of really progressing. Ultimately, that's usually just too demoralizing so the system stops pushing people forwards and is happy when they're stable. Can a person-centered, recovery based approach really do better? From a person-centered point of view the need for professional supports and services exists until the person develops enough skills to be self-responsible and enough

community based supports to live successfully regardless of their symptom level. The obvious implication is that the more services help people develop self responsibility and community supports the less professional services they'll need and we'll be able to move them on to lower levels of service or no service, even if they're still symptomatic, while we move on to new people in need. There's some hope.

From an illness-centered point of view the system developed a spectrum of services based on the acuity of the illness. People move on to lower levels of service when their symptoms are controlled. Since the illnesses tend to wane and wax, people tend to revolve instead of progress.

From a person-centered point of view we can develop a spectrum of services based on the person's recovery. Since people tend to grow and develop, despite setbacks, they tend to progress instead of revolve. There's some more hope.

Let's take it even further: Illness-centered point of view services respond to the level of symptoms with limited regard for the person's level of recovery. (For example, MediCal rules for paying for ongoing hospitalization are entirely dependent on clinical acuity without even considering whether the person is voluntarily engaged in their own treatment or not.) Why? Because when the focus is on the course of the illness, symptom relief, functional improvement, and even personal recovery are all presumed to run in parallel. Therefore, the level of service can be chosen based on symptom acuity alone. (For example, traditionally if someone is seriously suicidal with a plan, it doesn't matter what their functional level or stage of recovery is. Based on their symptoms they should be hospitalized.) In reality, however, symptom relief, functional improvement, and personal recovery don't always run in parallel. (For example, someone can learn a great deal of self-responsibility from an experience of high symptoms and some people can work and live independently even while experiencing severe hallucinations and delusions.) The illness-centered point of view sees these instances as rare, puzzling exceptions (because we frequently incorrectly attribute both improvements and deteriorations to illness factors instead of recovery factors. For example, we tend to assume someone is taking their medications willingly because their symptoms were controlled enough for them to regain insight instead of because they developed a trusting relationship with their psychiatrist or because they were cooperating temporarily so they could get unlocked.) Actually these instances of disconnection are more common than not. Our entire illness-centered spectrum of services design is built on faulty assumptions for most people. If that's why it doesn't work very well, a person-centered spectrum of services might do better.

From a person-centered point of view symptom relief, functional improvement, and recovery are all relatively independent and all need to be included in choosing level of service. (For example, if someone is seriously suicidal with a plan and "unengaged" we're likely to respond in a way that tries to increase their engagement with services, whereas, if they're "engaged, but poorly self coordinating" we'll try to help them learn from the crisis what changes they need to make to avoid future crisis and what self care skills they need to develop, whereas, if they're "self-responsible" we'll work on implementing their WRAP plan for self care and increasing their community integration and supports.) Services respond primarily to the level of recovery rather than the level of

symptoms. (For example, we might help someone get an apartment or a job even if they are psychotic or chronically suicidal.) Since we focus on the course of recovery rather than the course of the illness symptom reduction isn't necessarily a sign of progress or the need for a lower level of care, nor is symptom increase necessarily a sign of personal deterioration or the need for more professional caretaking. If the system's levels form a recovery based spectrum (For example, outreach and engagement, case management and integrated services, wellness and community integration) people are likely to be able to flow as they recover. (We realized that the Village's spectrum of services was weak in the wellness and community integration areas and that those areas needed to be strengthened to support flow.)

The important implication in this formulation, which is often overlooked in recovery based system design, is that every symptom need and every functional need must be able to be met at every recovery based level of service. Otherwise people will be forced to move backwards or forwards to inappropriate levels to meet their needs, just like they do in the illness-centered system at present. (For example, if a Wellness Center can't handle crises within its self help, peer support model they will end up returning someone to a lower level of care, like an urgent care center or hospital, even if the person's recovery hadn't deteriorated. On the other side, if an outreach and engagement program doesn't have any employment services, like day labor or "work for a day – house for a day," they will end up promoting people to case management to make them eligible for vocational services even if they aren't engaged enough to be ready for it.)

If recovery based services aren't seen as adjuncts to treatment, but instead are the framework upon which all services are provided, we can create a spectrum of services that would actually promote recovery and people would flow through it. I did an exercise with Santa Cruz county where we literally placed all their services and programs within a spectrum formed by the 8 Milestones of Recovery and they were able to see how people should be flowing through their system, which programs should be referring forwards and backwards to which other programs, and where people were being mismatched with services within their system. That clarity of vision simply isn't possible with an illness-centered spectrum because there are too many exceptions to the "illness treatment leads to life improvement" formula.

Here's a "generic" chart of a recovery based spectrum of services correlating level of recovery and services to help visualize how a person-centered paradigm plays out:

<b>Person-Centered Levels of Service (Recovery Based Spectrum of Care)</b>						
Extreme risk	Unengaged		Engaged, but not self coordinating		Self responsible	
Locked setting	Outreach and engagement	Drop-in center	Intensive case management	Case management Team	Appointment based clinic	Wellness center
Extreme risk (1)	High risk, unengaged (2) Poorly coping, unengaged (4)		High risk, engaged (3)	Poorly coping, engaged (5) Coping, rehabilitating (6)	Coping, rehabilitating (6) Early recovery (7)	
1:1 supervision Legal interventions Community protection Acute treatment Engagement	Welcoming Charity Evaluation and triage Documentation Benefits assistance Accessible medications Drop-in services		Case management Integrated services Accessible medications Supportive services Direct subsidies Rehabilitation		Appointment based therapy “Medications only” Wellness activities (WRAP) Self-help Peer support Community integration	

**2) The need for services at various levels of engageability, appointment keeping, and self-responsibility**

When most people look at that grid, after they orient themselves, they’ll look for our “core services,” the services we value most – ongoing medication and therapy – and notice somewhat resentfully that they seem to be stuck in the corner, seemingly pushed to the side by the large array of other services. This reprioritization reflects a disturbing reality buried in our usual paradigm: At its most traditional our mental health system can only treat people who are already easily engaged, keep appointments, and are self responsible. They must be able to come to clinics voluntarily, be able to describe their illness in depth for an intake evaluation, demonstrate insight by signing informed consent forms, and be responsible enough to follow treatment orders and return for further scheduled appointments all as a prerequisite for entering treatment. (For substance abuse treatment, in addition, they must agree they are addicted and stop using to enter treatment.)

The likely reality is that the majority of people, with or without mental illnesses, are not easily engageable enough or self responsible enough to use hardly any effective medical or mental health clinic treatment for any prolonged period of time. Yet all of our treatment systems act as though this isn’t the case. The resulting mismatch between what we’re offering and what people can use results in very few people benefiting from long term treatment. Consequently, the most common outcomes of our present system are

“never began treatment” and “dropped out of treatment.” That’s not flow; that’s spillage. While this may seem to help us keep caseloads down, it doesn’t really, because we’re often forced to clean up the spillage. We spend an enormous amount of money giving service to unengaged people. The process of spilling people out and then mopping them up is more likely to waste people’s lives than to lead to much positive growth and flow.

Traditionally, if someone can’t meet these prerequisites we assume it’s because they are too ill. (For example, a recent discussion of the CATIE drug study where the majority of people discontinued treatment concludes that “patient-initiated drug discontinuation appears to be a core illness behavior from schizophrenia onset to chronic illness.”) The next logical step is to force them to take medications so they will be less ill and therefore able and willing to come to a clinic for an intake assessment and ongoing appointments. Usually that doesn’t actually work (and that’s not just because hospital stays are too short to decrease symptoms – I doubt IMD and Board and Care discharges do much better).

In many places the only alternative to self responsible clinic treatment is involuntary hospitalization. Many clinicians and families are frustrated because the law doesn’t permit involuntary treatment of everyone who isn’t easily engaged and self responsible so they urge broader laws without ever addressing if we need such difficult prerequisites in the first place: Do people really have to sit through intake assessments to get help? Do they really need to agree that they have a diagnosable major mental illness to take medications usefully? Do they really need to set goals and design treatment plans to be motivated? Do they really need to come to regular appointments?

From this perspective almost every programmatic advance whether day treatment, half way houses, board and cares, ACT teams, psychosocial rehabilitation, consumer run services, etc. can be seen as an effort to treat people who don’t meet those prerequisites without locking them up. Unfortunately, almost all of these programs are seen as adjuncts to traditional clinic care rather than as precursors to it.

From a recovery point of view, the standard clinic is an appropriate treatment only for people who are already fairly far along in their recoveries; people who are engaged, self responsible, and have significant skills and supports in the community. Therefore, clinics are rarely the appropriate first level of treatment even though we usually think they should be our system’s major front door.

Flow can only begin if we create “pre-clinic” services that meet people where they’re at. These are outreach and engagement services. (Incidentally, they can be voluntary or involuntary. There’s no law against long term involuntary outreach – say for two years – as long as we’re not stalking.) What is available for people who want help besides appointment based intake assessments in a highly stigmatized, crowded clinic? Would a home visit be as effective as dragging someone into the hospital?

Levels of service should begin with outreach and engagement for people who aren’t engaged. The next level to flow into once someone is engaged should be easily accessible, flexible services, which include staff to help coordinate services for you and who tolerate poor participation as they teach self responsibility. Only then are people likely to flow into a clinic as they’re designed today and be able to benefit from it. (Of

course, by then it's reasonable to wonder if they should be going to a Wellness Center instead. Exactly who is best served in a clinic?)

### 3) The need for services to be growth oriented instead of care taking

Once we create a full recovery based system of care including plenty of services for “unengaged” and “engaged, but poorly self coordinating” people we have to look at what services we're giving, and ask ourselves if they promote flow or not?

Traditional treatments are illness based, but we still must deal with the people who have the illnesses. The traditional overall approach is to take care of the person until their illness is treated enough that they are well enough to take care of themselves. This caretaking is usually seen as ancillary to the treatment and designed to facilitate the “real” treatment. By contrast growth oriented services are designed to teach people how to take care of themselves and use supports regardless of how ill they are. They are seen as crucial to promoting recovery as treatment itself. Here's a grid contrasting care taking and growth oriented services:

	<b>Care taking services</b>	<b>Growth oriented services</b>
<b>Unengaged</b>	Forced treatment Protection Benefits establishment Acute stabilization	Outreach and engagement Peer bridging Concrete quality of life goals Relationship building
<b>Engaged, but poorly self-coordinating</b>	Structure Making decisions for people Case management Chronic stabilization	Supportive services Skill building Personal service coordination Collaboration building
<b>Self responsible</b>	Benefits retention Maintenance therapy and medication	Community integration Self-help Peer support Wellness activities Growth promoting therapy

Notice that this grid is person centered, not illness centered: The rows are built on how far along the person is in their recovery, not how far along their illness is in its treatment (Illness centered rows by contrast would be: acutely ill / at risk, symptoms stabilized but interfering with function, and symptoms stabilized and ready to rebuild, for example).

Notice also that the services in both columns “work.” People who are unengaged can benefit by being forced into treatment. Unfortunately, it rarely leads to them becoming engaged. Engaged, but poorly self-coordinating people can benefit from structure and other people making decisions for them (if they don't rebel and become unengaged again) but it rarely leads to them becoming self responsible. And self-responsible people can be maintained in treatment and on benefits, but it rarely leads to them becoming productive and integrated into the community. The difference between care taking and growth oriented services, and the reason for transforming, is not to necessarily to achieve greater effectiveness, but to achieve greater flow. Absent a major breakthrough in a person's illness treatment (which would likely benefit either approach) the care taking

services need to be ongoing while the growth oriented services may well be able to move many people on and open up space for the next person in need.

Consider the example of board and care homes vs. halfway houses: When the state hospitals first started closing it was considered too large a step for people to move directly into their own apartments. Halfway houses were set up so that people could get accustomed to their new neighborhood, learn where the doctor, the grocery, the bank, and the laundromat were, find an apartment they liked, and brush up on their independent living skills. They were designed as a growth oriented service. Over the years, however, board and care homes have evolved to take care of people who in the past may have been in state hospitals indefinitely. They take care of meals, laundry, housekeeping, pills, money, even some social activities, for their residents. There is generally no teaching component or expectation of moving on to your own apartment. Licensing overtly codified these caretaking responsibilities, but not the teaching responsibilities. By now there are large numbers of board and care homes and virtually no halfway houses. Because the board and care homes give care taking services with negligible positive flow, the “good ones” are always filled. Only the ones who inadvertently create substantial numbers of unengaged or extreme risk people seem to have new vacancies.

If we are going to create flow, we’ll have to create large amounts of effective growth oriented services. Unfortunately we don’t usually consider many of the items on either of these columns of services to be actual treatment (once again, because these services are person-centered, not illness-centered). They’re not readily reimbursed or considered “treatment.” Both sets tend to be relegated to lower paid, unlicensed, less highly educated staff (there doesn’t even exist staff training programs for most of these service skills) and the higher paid, licensed, and highly educated staff in general avoid providing these services themselves. The growth oriented services require more skills, personnel, and resources to provide than the care taking services require (at least in the short run). Ultimately, there won’t be enough talented people or resources to provide a full spectrum of growth oriented services if we merely transform care taking services into growth oriented services. We’ll also have to transform some clinical treatment services into growth oriented services. Doing so will require a substantial power shift in our system.

#### **4) The difference between growth oriented cultures and structures**

One of the most concrete ways of promoting flow is to create time limits (e.g. “This is a 30-day rehab program” or “This is a 12 week skills building group therapy.”) Unfortunately, time limits can be unrealistic or even destructive. Most real people actually grow and recover at a rate faster or slower than the program’s “prescribed” rate and some people don’t grow at all. Sometimes time limits can even backfire as people seem to regress as their time limit approaches to “prove” they’re not ready to move on. On the other hand, growth is often dependent on effort, and without time limits there may be limited pressure to exert effort. Sometimes it seems like growth only happens once people are faced with a time limit. Both staff and the people being served are prone to these fluctuations in motivation and effort. Services without time limits seem to inhibit flow simply because of their permanent availability.

This dilemma is more easily resolved theoretically than practically. Theoretically people will move on when they've achieved the needed growth whether they did that faster or slower than predicted. Theoretically staff and the people they serve will maintain motivation because of the benefits of growth alone without external pressures. Practically these desirable theoretically behaviors are only likely to happen with additional external motivation, either from the programs structure or its culture or both. If a program can create and maintain a strong growth oriented culture it will need less structural pressures.

A growth oriented culture has many elements: Staff need to believe that growth and recovery is the expected, usual outcome. They need to view "stability" as stagnation, an inadequate outcome. They need to be hopeful and instill that hope in the people they serve. They need to emphasize possibilities instead of disabilities. They need to feel confident in their ability to promote growth and recovery. They need to focus their emotions more on celebrating successes than on avoiding blame for failures. They need to view setbacks as inevitable and opportunities for learning and further growth rather than as failures and reasons to give up. They need to promote growth oriented risk taking instead of risk avoidance.

A program's leadership should use structural elements - like time limits, case loads that go up if people aren't moved on, outcome measurement systems, or staff incentives – to help create and maintain the culture. If leaders instead rely on structural elements to create flow without creating a growth oriented culture, there is likely to be lots of conflict and evasive efforts.

##### **5) The difficulties maintaining relationships as people grow and flow**

One of the most difficult obstacles to flow is the changes in or even discontinuations of relationships that accompany growth and flow. Traditionally spectrums of care designs struggle terribly at the transition points because relationships with staff are disrupted precisely when people are trying to stretch themselves. Presumably it would be ideal for the same staff to maintain relationships with people even as they flow through various services and their needs change. Unfortunately, that's not a realistic solution, since different levels of services are likely to be in different places and staff may not be good at providing every level of service even if they could.

Recovery offers a new opportunity to deal with this obstacle because relationships between staff and the people they work with are different in the first place. In recovery programs staff must work together in true teams. People will regularly have relationships with a number of different staff on the team and staff will have a number of different roles with any given person they're working with. When contrasted with traditional programs, recovery programs tend not to restrict multiple relationships or roles. Boundaries tend to be much lower and more fluid. As a person changes, the expectation is that their relationships with staff will change. Within the recovery culture changing relationships are part and parcel of growth and recovery. (For example, a common "desirable" relationship conflict in a recovery program occurs when the person wants the staff to continue to do things for them while the staff wants them to grow and use their new skills to do things for themselves.)

The enduring core of the relationship is more likely to be their “real” relationship than their “therapeutic” relationship. Recovery relationships tend to extend beyond the walls of the office and the limits of the therapy. Therefore, even when someone “graduates” from a given program, or from treatment altogether, they may still have a relationship with their old staff. The responsibilities and expectations will have drastically changed, but they’re not “terminated.” (For example, there are literally hundreds of people at the Village and graduates who have some relationship with me – perhaps just saying hi in passing, or my being their customer at the café, or sending me a Christmas card, or playing softball together, or being coworkers, or them showing me how much their child has grown, or inviting me to their wedding – but I am no longer their treating psychiatrist. Since we always had multiple roles and relationships, ending my medication prescribing relationship with them doesn’t end our relationship entirely.)

The traditional severe restrictions on relationships between staff and the people they work with make the relationship transitions associated with flow and graduation much more disruptive and traumatizing than they are in a recovery program.

(Incidentally, there is a substantial benefit to staff if they continue to have some contact with people who have “moved on.” We get to see the people we care about continue to grow and recover even after they leave us. And that can inspire and even transform us.)

#### **6) The need for community integration to graduate people from professional services**

As we started to graduate people and they come back and tell us about both the good and bad things that have happened, we’ve begun to realize that their most serious difficulties weren’t usually from their symptoms relapsing or their functional deficits or even from a lack of self-responsibility. They were usually from loneliness. They didn’t really have much of a network of friends except the people they’d met at the Village. They hadn’t really found a niche in the larger community. Our community just isn’t really very welcoming.

Promoting community integration turns out to be an entirely different kind of work than we’re used to, or than we’re good at. It isn’t about accepting our members or really listening to them or treating them or skill building or even advocacy. It’s a whole different thing. We’re really only just beginning to learn how to do it.

I suspect promoting community integration is probably about helping our communities recover. After all how healthy can a community really be if it has to hire a lot of paid staff to care about people who just want the opportunity to have a life like everyone else now that they’ve struggled so hard to overcome their inner battles?

## **Speaking out in Public**

**By Mark Ragins, MD**

In public I rarely tell people I'm a psychiatrist unless I'm pressed. I've learned that if I tell them they'll look at me like I've grown one of those glowing eyes out of the middle of my forehead, unsure if I have some strange power to see inside them, and then draw away from me. Sometimes they'll come up to me later when I'm all alone or call me to secretly ask me about a serious problem: It might be an elderly alcoholic parent who's losing it and doesn't want to be put away. It might be a young daughter whose school called because she was caught forcing herself to vomit and was talking about suicide to her friends. It might be a teenage daughter using drugs, hanging out with the wrong people and ditching school or a teenage son who just told them he's gay. It might be a sister who won't leave the husband who keeps beating her up because she loves him or a brother with schizophrenia who won't take his medications, wanders the streets and comes by occasionally asking for money, dirty and frightening. It turns out I'm an expert in secret places.

If we're going to be effective mental health advocates, we're going to have to come out of the shadows and speak out in public. Our community needs to know that we're entering a period of massive transformation in public mental health. Although they'd rather we stay quietly out of sight, the changes we're making are going to effect everyone and they should know what we're up to. All over the country a recovery based transformation is underway. California, as usual, is leading the way. We have some reliable funds from Proposition 63, the Mental Health Services Act along with a blueprint for change. We've been planning carefully, inclusively, and very publicly. We have the recovery vision to guide us. It's happening.

It's rare for any major public system to transform itself. Except for being more crowded, more run down, and cut back, school is pretty much the same as it was when I was a kid. So are jails, and courts, and police. So are public libraries and parks. Technology changes, but services don't. I could argue that the last major transformation of a public system was also us when mental health was deinstitutionalized some 40 years ago.

Before you groan, would you like to know how that transformation turned out? I know you think you know – just look at the streets and the jails – but do you really? There was a major study done by Courtney Harding and others at NIMH that carefully found out what happened to the patients with schizophrenia 25 years after the state hospitals in Vermont and Maine were closed. It showed that about two thirds of them recovered (meaning that they didn't have disturbing symptoms or need treatment, they weren't in hospitals, on the streets or in jail, they were working or engaged in other productive activity and they had a social life indistinguishable from their neighbors). How can that be? you protest – just look at the streets and the jails.

But if you only look at the streets and the jails you're going to be missing most of the picture. It turns out there are a lot of mentally ill people. Even if only a small portion are doing very poorly that's still going to be a lot of people and have a big effect, but they're really only the tip of the iceberg. Most of the iceberg is actually quietly doing well.

Because of stigma they're hiding in plain sight as your neighbors and coworkers. How do I know this? Because I'm an expert in secret places.

Built out of stigma and fed by fear a compelling story of the failure of deinstitutionalization has been told to us over and over again. Rarely has the drumbeat of bizarre, dangerous failures been interrupted by the more common stories of success. After a few decades it has become gospel even though it's wrong for most people.

If you're beginning to feel any doubt, consider two things:

First, the rapid closure of the state hospitals in California occurred during the 1960's bottoming out to near current levels by 1970. The increase in jailed mentally ill didn't really begin until 1980 and has been escalating ever since. Why the time lag? Because the cause for the increase in jailing wasn't really deinstitutionalization; it was caused by the war on drugs that began in 1980 and has escalated ever since. Many mentally ill people use drugs and that's why the vast majority are in jail today, not because of their psychosis. Also beginning at the time we became less and less tolerant of poverty and began turning to jail more and more frequently to deal with problematic poor people. Many mentally ill people are problematic poor people and are jailed as a result. (In no housing market in America are SSI payments adequate to afford housing.)

Second, in my experience with homeless and jail diversion mentally ill people only a minority (I'd estimate about 20%) had reasonably normal childhoods followed by a disabling major mental illness. The vast majority were already impaired in childhood. Many come from abusive and neglectful families or foster care placement. Many were in special education, especially SED (Severely Emotionally Disturbed) classes, have reduced literacy, and dropped out of school. Many have juvenile substance abuse and juvenile justice experience. LA County Jail is often described as the largest de facto mental hospital in the country. Perhaps more accurate would be to call it the largest display case of the failures of our children's services, foster care, child abuse prevention, special education, juvenile justice, and substance abuse prevention systems. (They are actually the failures of our system 20 years ago. We have no idea if we're doing better or worse now.)

Our transformation plans need to take into account these rarely publicized realities of our present situation.

We attempted to implement deinstitutionalization using the same medical model services and relationships we used in the state hospitals. After 40 years we've learned how to do things better, but mostly in isolated programs. Now with the recovery based transformation we can implement these improvements pervasively. Here are seven changes we'll be implementing and how they'll affect our communities:

*1) We're not going to focus just on treating illnesses, but on building lives.*

Somehow we've expected that if we handle treating peoples' illnesses other social service systems would handle their other needs. As budgets have tightened we've narrowed our

focus more and more. Bluntly put, the other social service systems have failed us: People with mental illnesses struggle to qualify for Social Security and to spend the money for food, clothing, and shelter, but no payees are provided. Mentally ill people rarely get permanent jobs through Vocational Rehabilitation Departments or complete educational programs through Disabled Student's offices. Mentally ill people have high rates of having their Section 8 certificates withdrawn and having their children removed by the Department of Children's Services instead of receiving family preservation services. Mentally ill people rarely do well with standard health care services, substance abuse services, probation, or parole.

It's not that mentally ill people are incapable of succeeding at these things. It's that services must be adapted to meet their needs to be effective. Mental health systems need to actively collaborate with and support these other social service systems for them to be effective and sometimes we'll even need to provide the services ourselves. We're going to be approaching these service systems to work together and advocate to make it harder for them to ignore mentally ill people.

We're going to keep track of our Quality of Life outcomes (finances, housing, employment, education, legal, etc.) so that we'll all know how we're doing and whether tax money is being well spent. We'll be able to hold each other accountable for building lives.

Focusing on building lives instead of treating illnesses will also dramatically improve our engagement rates. Many mentally ill people don't believe they have mental illnesses (at least not the way our system defines them) and even more mentally ill people don't want our medications and therapies. As a result, they often stay away from us, suffering and struggling on their own, and disrupting everyone else when things go badly. On the other hand, many of these same people would like to rebuild their lives. They will accept charity, but not treatment. They will accept quality of life support services, but not clinical services. If we offer substantial welcoming, charity, quality of life support services and advocacy we will engage far more people than we can with treatment and rehabilitation alone. This change will make the involuntary outpatient treatment argument virtually irrelevant because it will be possible to engage and assist almost everyone in need.

People's lives shouldn't be lived within the confines of mental health program walls, whether hospitals, board and cares, day treatments, club houses or rehabilitation programs. Their lives should be lived in the community. Therefore our staff have to stop hiding with them behind clinic and asylum walls. We have to come out into the community helping them rebuild their lives – supporting them, advocating for them, getting involved directly in their lives.

*2) We're going to build on the reality of recovery.*

Too much of the history of mental health treatment has been built on the hopelessness of incurability, while the reality is that the majority of people with serious mental illness if given care and support and a full opportunity to return to the community will recover. We know this from hearing from people who have recovered. We know this from the

moral treatment outcomes from the 1800s. We know it from Courtney Harding's longitudinal follow-up studies from Vermont and Maine. We know it from the WHO studies of the natural outcomes of schizophrenia in third world countries.

We will create opportunities, not warehousing.

Chronic illnesses don't have to mandate hopelessness. For acute illnesses recovery results from symptom elimination and cure, but for chronic illnesses recovery results from:

- Achieving self-management of the illness
- Maintaining hope and self-image
- Carrying on with life through rehabilitation and adaptation
- Replacing professional supports with natural supports in the community

For acute illnesses recovery is illness-based.

For chronic illnesses recovery is person-based.

Even with symptoms lives can be rebuilt, disabilities can be rehabilitated, adaptations can be made by people and by their communities, and destruction can be overcome. We're going to expect, not illnesses to be cured, but people to recover:

- 1) Functions will be recovered - as in the ability to read, to sleep restfully, to work, to have coherent conversations, to make love, to raise children, to drive a car, etc.
- 2) External things will be recovered - as in an apartment, a job, friends, playing in a band, a spouse, a car, family relationships, stereo, TV, educational programs, etc.
- 3) Internal states will be recovered - as in feeling good about oneself, satisfaction, self confidence, spiritual peace, self-identity other than mentally ill, self-responsibility, etc.

We will create recovery based services and systems.

For people with mental illness to be included in our communities they have to be responsible just like everyone else. No longer will we plead incapacity and irresponsibility to help people with mental illnesses avoid their responsibilities, legal or otherwise. After all, it's a rare person who really doesn't know right from wrong. The vast majority of people with mental illnesses are arrested for drug crimes and even if your voices are telling you to steal and to use drugs, you know it's illegal and should be held accountable. It may be tempting to get out of responsibilities by pleading mental illness, but the cost is exclusion from community life. No one wants an irresponsible neighbor, employee, spouse, or parent. Not everyone, of course, with mental illnesses is responsible, but almost everyone can become responsible. Our job is not to help people avoid responsibilities, but to support them to meet their responsibilities.

We can all learn to deal with our fears and tolerate living with people with mental illnesses even if they have symptoms (after all mental illnesses aren't that dangerous or contagious) if we can support them to act responsibly.

We're going to emphasize self responsibility, wellness, natural supports, and community integration – not professional liability, illness, professional supports, and segregation. We need to build our community's caring capacity not its caretaking capacity.

*3) We're going to integrate substance abuse treatment into all of our programs.*

Most of the really damaging things that happen to people with mental illnesses and most of the destructive things that they do are a result of drug and alcohol abuse – just like everybody else. It's time for us to stop expecting the substance abuse treatment system to help them for us. They've got a lot less resources than we've got. They've got their own serious problems with stigma. They've got the criminal justice system breathing down their necks. And they just can't handle most of our people anyway. We can learn a great deal from them, especially about recovery – after all they've been at it for a long time - but we need to do the work ourselves.

I don't mean that we'll create special dual-diagnosis specialists and programs. All of our staff must become dual-diagnosis competent and able to deal effectively with substance abuse on a daily basis. We'll also need to move beyond where most people in the substance abuse treatment system are and work with people who are still actively abusing substances, getting into trouble, and not ready to stop. We'll need to master engagement, harm reduction, and motivational interviewing techniques to be effective. We'll have to work on our own stigma to get the work done.

*4) We're going to build specialized programs to work with transitional age youth (TAY).*

There are a lot of people who first begin struggling with mental illnesses in their youth. There are a lot of children with mental illnesses and emotional disturbances who struggle with growing up. And there are a lot of “throw away kids” heading towards our streets and our jails. We're going to be there working to reclaim them to have a real impact.

Sometimes we'll be helping them to transition into adult recovery-based services hopefully bypassing years of suffering and disability and sometimes we'll be helping divert them from adult mental health services entirely as they mature into functioning adults. These are new programs for us and we're going to have to develop the techniques we need as we go, but we have our recovery vision to guide us.

*5) We're going to target highly problematic people for intensive assistance*

There are a relatively small proportion of people with mental illnesses who are having the most difficulty. They are not responding well to our “one size fits all” system. We're not going to respond by locking them up, even if you highly publicize our worst tragedies and even if you threaten to lock them up in jail if we won't. What we are going to do is give them very intensive, very accessible services in the community designed just for them. That works the vast majority of the time even without additional coercive powers. We're devoting about half of the first set of new Mental Health Services Act programs to this effort, calling them Full Service Partnerships, and enrolling people not based on our own clinical criteria, but based on what who the community feels is most in need (initially mostly homeless, jailed, and repeatedly hospitalized people).

I can warn you, you're going to have two problems with this approach from the beginning: 1) It won't feel fair. Some people are going to be offered lots of help, including housing and lots of staff attention, and some people are going to be offered very little help; and 2) It won't feel right. In some ways the people who are selected for the most help will seem to be the least deserving. It will work out that people who don't take their medications, abuse substances, are irresponsible, don't take care of their housing, and/or cause trouble by doing illegal things will be offered lots of help while people who are responsibly working with us to improve their lives and recover won't be. Why would we do that? Because that's what will work to get everyone living reasonably in our community.

*6) We're going to openly hire substantial numbers of people with mental illnesses.*

We know they will be suspect at first. Even most of our staff don't believe people with mental illnesses can be effective colleagues, but they can. You'll probably make fun of us at first, saying we're letting the inmates take over the asylum or that this just proves we're all crazy, but we'll stick to it. They'll probably need some special training and supports at first – so did Jackie Robinson – but eventually they'll just be a normal part of our workforce.

Believe it or not, there's already lots of people with mental illness working very effectively in our system. Some are open about their experiences and even use self disclosure to help other people recover too and some are still “in the closet.” (By the way, you already have valued coworkers with mental illnesses too, but they're pretty hidden.)

We're not going to make it safe for all those people to come out of hiding until we openly hire more people with mental illnesses. Ultimately, hiring people with mental illnesses is the single most important stigma busting thing we can do. If we won't trust them to work effectively, why should you? But when they do succeed – and they will if we keep our expectations and our standards high - they'll have earned your respect and a place in your workforce and our community too.

*7) We're going to actively work in our communities to make them more welcoming*

One of the main problems with deinstitutionalization is that the community didn't accept it. Most people still believe that they shouldn't have to be neighbors or coworkers or parishioners with people with mental illnesses. Most of us still believe they should be put away somewhere, taken care of, and most of all, that we should be protected from them. How do we really expect them to thrive in our communities when that's how we feel about them?

Our communities can do better. We can be fair to people with mental illnesses. We can include them in our lives. And we can even welcome them. The antidote to stigma is not, contrary to popular and professional opinion, education; it's welcoming. To really

fight stigma, I'd rather have an training and employment program at Walmart for people with mental illnesses, so all the staff their could build relationships with them as colleagues and relate to them directly, than give a lecture about schizophrenia to the Rotarians. To truly change the lives of people with mental illnesses, we need compassion not pity, relationships not avoidance, acceptance not ostracism, and inclusion not segregation.

It's not too much to ask for our communities to welcome people with mental illnesses without us having to hire an army of professionals, paraprofessionals, and consumers and their families to care about them. We can all care.

This advocacy and community building work is difficult. We may not be very good at it and there isn't much money to pay for it. Nonetheless, we have to do it if deinstitutionalization is really going to work; if people with mental illnesses are really going to live full lives in our communities. We're going to have to stop being so secretive, come out of the shadows, and speak out in public.

And you're going to have to listen.

## **Afterward: Keeping Perspective and Staying Sane**

As I look back over this toolbox of articles, I feel a little overwhelmed. I never expected it to be this long. Of course I never expected to be involved in so many ways at so many levels in the transformation effort or to meet literally hundreds of other people passionately working on it (or to learn to make PowerPoint slides, use a memory stick, and make tables in Word).

One line sticks out for me at this point: “The further we go along with hiring and supporting consumers, as with most of this transformation effort, the more detailed and complex everything gets, but also the more plausible it seems.” If we can keep our perspective and our sanity we can probably do this.

A few thoughts I picked up along the way:

First, governmental programs are designed to be stable. And they should be. We want the DMV to keep doing driving tests even if the personnel changes. We want the FDA to keep inspecting meat and pills. We rely on our governmental services to be there when we need them. They need to be stable and reliable. They don't really need to be “learning cultures.” It's only when we're trying to change something, or worse yet, trying to transform an entire system that stability is a bad thing. Then we experience it as resistance to change. We run into so many unforeseen obstacles we're sure someone must be fighting against us. As far as I can tell there aren't many enemies hiding behind the scenes planting traps to destroy us. Mostly we're fighting stability. I try not to take it so personally.

There's another important lesson here: If we want this transformation to last we have to build it into the system's infrastructure so it's part of what's kept stable in the future. That's why a couple of these papers are about personnel parameters and human resource practices. That's also why our most important work will eventually be in the arcane, mind numbing world of MediCal regulations.

Second, this transformation is slow. Even if leadership is pushing it hard, even if there's strong advocacy and political pressure, even if money and jobs are at stake it's going to be slow. There's multiple checks and balances, multiple layers of overlapping oversight, multiple layers of accountability built into everything. And there should be. If there weren't corruption would be much worse. It seems to me it's taken us almost two years to begin any program building, not because anyone is holding us back intentionally or even because everyone is incompetent. It's just that this is such a big change it has to go through lots of levels and each level takes time.

Infrastructure changes will be even slower than services changes. It's easier to get the system to do something new (what we're doing now for the most part), than to get it to change itself. It's likely we will have a whole variety of recovery based programs for years before we build the infrastructure to support them.

Third, transformation doesn't happen all at once. It progresses. There's a description by Malcolm Gladwell in “The Tipping Point” of a study about how corn farmers in the

1920s changed what kind of corn seed they all used over the course of a decade. Here's my version of how they divided the farmers into five groups depending on when and why they changed corn seeds:

1) Innovators: These people like to try new things whatever they are. They want to be on the cutting edge and are willing to take risks. They just need to be exposed and inspired to try something new.

2) Early Adaptors: These people don't go for every new fangled thing or follow every fad. They're thoughtful about change, but willing to take risks if they're convinced it's a better way. They're often respected leaders. They need to understand how something new will work to try it.

3) Early Majority: These people will try something new, not because they're inspired or really understand it, but because the early adaptors are doing it and their judgment can be trusted. They need to be reassured that they're going to actually be able to do this new thing and understand how it'll make their life easier and better to try it.

4) Late Majority: These people come on board because it seems like everyone else is doing it and they don't want to be left behind. They need to believe that the change is low risk and inevitable to try it.

5) Laggards: These people are resistant to anything new. They like the comfort and familiarity of what they're doing. They already think they know best and don't need to learn anything new. They certainly don't want to try something risky or unproven. They will be the last ones to be converted, if at all, no matter what you do, so just make sure they don't undermine your efforts with everyone else. (By the way not everyone who objects loudly is a laggard (many of those people are frustrated passionate people who mostly need to believe they're not going to be heartbroken again to join in) and every laggard doesn't object loudly.

It's helped me to think of this schema and realize that every group is represented when I look at a new group at a workshop or a new clinic to be transformed. It's also helped me realize that not everyone needs the same things to join in. I'm an innovator and like talking to other innovators. Being inspirational and breaking down walls creating new ideas works very well with them, but that's not what everyone needs. Some people need reassurance or practicalities or a sense of inevitability more than inspiration. Different groups should be targeted at different stages of our transformation efforts.

Fourth, transformation is very complicated and has to occur in multiple domains at once. Ken Wilber's admittedly quite dense books helped me organize this complexity and focus my efforts. He divides every issue into four domains using the individual vs. the collective and the inside vs. the outside. Here's my version of his schema:

	<b>INSIDE</b>	<b>OUTSIDE</b>
<b>I</b>	VALUES EMOTIONS	BEHAVIORS PRACTICES
<b>WE</b>	CULTURE MISSION	SYSTEM INFRASTRUCTURE PROGRAMS

To help orient you to use this schema here’s some examples: Psychoanalysts focus on the “I-Inside” Domain, behaviorists focus on the “I-Outside” Domain, anthropologists focus on the “We-Inside” Domain, and system analysts focus on the “We-Outside” Domain. Our society tends to focus more on the two outside domains than the two inside domains because they’re easier to observe, measure, and hold people accountable for. On the other hand, Bill Anthony writes about a need to focus not so much on Evidence Based Practices (Outside Domains) as Evidence Based Cultures (Inside Domains) if we’re really going to achieve recovery based transformation. There’s a study, for example, that shows that the same high fidelity Evidence Based Practice of supported employment creates very different outcomes depending on if the staff believe people with severe mental illnesses can work or not. Working on the Outside Domains is unlikely to help the underperforming programs. They need to focus on their Inside Domains.

Ken Wilber makes the point that most of the time when we’re problem solving or trying to change something we focus on only the one domain we’re most comfortable with, usually without even realizing we’re neglecting the other domains. Many arguments occur because the two sides are focused on different domains and see the problem very differently. For example, a mental health director might identify his major problem as resistive staff who don’t believe in recovery (“I-Inside”) while the staff believe the major problem is the distortions revenue generation demands have placed on their practice (“We-Outside”). Probably both are right. All four domains must be addressed for true transformation to occur, or whatever domain is weakest will hold back the entire process.

One of the major reasons this toolbox ended up so long is that I ended up working in all four domains because almost everywhere needs to work on all of them.

Fifth, there are a lot of passionate and motivated people working very hard on this who are totally frazzled already. This is a marathon, not a sprint. Every decision doesn’t have to be a life and death battle. I know the stakes are high and that this is a once in a lifetime opportunity, but the road to recovery is wide. We can meander around, even make a few wrong turns, and still get there. What we need more than to be sure that we’re going in exactly the right direction is to be sure there’s lots of us walking (and running) together and that we support each other emotionally. We don’t always have to

be in perfect agreement, but we do have to be in alignment, walking the same direction. To do that, we have to keep our vision clear and our passion strong. We can't do that if we're too frazzled. This is going to take so long that many of us probably won't even be there at the finish line. This is probably going to have to be a relay race so make sure you have people around you who can carry the baton too.

We need to take time to care of each other.

Keep in touch.

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