Recovery Within Diverse Populations

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Introduction

Recovery for mental health and/or co-occurring disorders must also include the notion of healing. This is particularly true for communities of color and those who are lesbian, gay, bi-sexual or transgender (LGBT). These are individuals who must not only recover from their mental health disabilities/substance use disorder, but they must also heal the wounds suffered by virtue of their minority status. The oppression and trauma brought on by racism, sexism, colonization, homophobia, poverty, cultural and language isolation, place them at even greater risk for emotional/behavioral problems. Recovery and healing is an ongoing process and a journey that cannot be taken alone. It requires a strong support network, competent caregivers, resources to provide the services, and an individual who is willing to push his/herself to find the place of healing and recovery. Most importantly, it requires a belief that recovery is possible.

Mrs. Rosalyn Carter stated in her opening remarks at the 2003 Annual Carter Center Mental Health Symposium that the single most important lesson learned in the field of mental health since she championed the cause as First Lady over twenty five years ago is the recognition that people with serious mental health problems do recover. This simple yet profound change has major implications for the goals of therapy, the development of treatment plans, the role of the consumer and his/her support system and the need to broaden the definition of what constitutes good mental health outcomes.

Background on Diverse Populations

According to the 2000 Census, African American, Asian American/Pacific Islanders, Hispanic/Latinos and Native American/American Indians make up 30% of the total U.S. population. It is projected that by 2025, they will increase to 40% of the total population and by 2050 they are projected to compose almost 50% of individuals living in the United States.

Hispanics/Latinos make up 13% of the population, African Americans 12%; Asian Americans/ Pacific Islanders 4%; and American Indians/Alaska Natives make up one percent of the population. Recent estimates of the gay and lesbian, bisexual and transgender (LGBT) population place it between 1 and 5%. The LBGT population is composed of a

diversity of sexual and gender minorities. It is a microcosm of the larger society and its members span every race, ethnicity, religion, and income bracket.

Hispanic/ Latinos are, for the first time, the largest of the four major racial and ethnic groups. By the year 2050 nearly one in four Americans will be of Hispanic origin (U.S. Census Bureau, 2000). During the same time period, the Asian American/Pacific Islander populations will more than double, increasing from 4% to 9%. The percentage of Caucasians is projected to drop from 68% in 2002 to 53% in 2050, while the proportion of African Americans and American Indians will increase slowly or hold steady at the current rates.

Asian Americans and Pacific Islanders represent over fifty one different ethnic groups from countries all across Asia and the Pacific Islands and speak over one hundred Asian and Pacific Island languages and dialects. According to the 2000 census, this population includes 30 groups which are of Asian descent and 21 groups are Pacific Islanders.

According to the Bureau of Indian Affairs, there are approximately 562 tribal governments that are federally recognized. Additionally, the legal and political status of citizens of federally recognized tribal governments must be noted as unique "government to government" relationship that is grounded in treaty rights. There are approximately 1.4 million tribal members under the Bureau of Indian Affairs trust umbrella (U.S. Department of the Interior, 2002). In contrast to this figure, 2.5 million citizens self-identified as American Indian/Alaskan Native in the U.S. Census (U.S. Census Bureau, 2002). The legitimate claims of membership/decedent heritage of the American Indian/Alaskan Native population are more likely around two million

Each Latino subgroup e.g., Mexican American, Puerto Rican, Cuban, Nicaragua, South American, Central American is likely to have important implications for the resources available to address the specific subgroup's mental health needs. (Gil & Vega, 1996).

The African American population has seen a sharp increase in the number of foreign born over the past few years. The term African American itself is somewhat misleading as not all who are designated as such are of African ancestry. The largest number of Black refugees and immigrants are coming from Ghana, Nigeria, Ethiopia and Somalia in Africa, and Haiti, Jamaica and the Dominican Republic in the Caribbean (Logan and Deane, 2003).

Much of the increase in population is due to the number of in immigrants and refugees entering this country. The census counted 55.9 million persons who were either foreign-born or who had at least one foreign-born parent. This combined group represents about 20 percent of the total U.S. population (Bureau of the Census, 2002). The increase in the foreign born population is primarily in the Latino/Hispanic and Asian American communities. Almost half of the total population of Mexican Americans in the U.S. are immigrants (U.S. Census 1999) and almost eighty-eight percent of Asian Americans are either foreign born or have at least one foreign born parent. In addition, there are 1.5 million Afro-Caribbeans and over 600,000 Africans in the U.S. Although this is a small proportion of the total African American population, foreign-born Blacks accounted for 17 percent of the *growth* in the non-Hispanic Black population during the 1990s. Although often

overlooked, Afro-Caribbeans, for example, now outnumber and are growing faster than well-established ethnic groups such as Cubans and Koreans.

Assessing one's "legal" status can be divided into those who are foreign born, either immigrant or refugee, those who were born and raised here but have ancestors who came from another country and those who are native or indigenous and were colonized by the United States as happened to the American Indians/Native Americans and Native Hawaiians and Pacific Islanders. The impact of colonization, having one's land taken away and having one's native language and culture made illegal has left many deep emotional scars within these communities.

Mental Health Needs

> "*The current mental health system has neglected to incorporate, respect or understand the histories, traditions, beliefs, languages and value systems of culturally diverse groups. Misunderstanding and misinterpreting behaviors have led to tragic consequences, including inappropriately placing individuals in the criminal and juvenile justice systems. There is a need to improve access to quality care that is culturally competent*" (President's New Freedom Commission on Mental Health, 2003).

Two other major reports that address the mental health disparities of diverse populations are the Institute of Medicine's report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* and the Surgeon General's Report on *Culture Race and Ethnicity* (2001) both highlight the disparities in treatment for communities of color. The results of the IOM report find that even when care is available, it is of a poorer quality than that found in the white population. Immigrant and refugees, and others with limited English proficiency face even greater challenges because of the cultural and language barriers.

The need to increase the number of bicultural and bilingual service providers is reflected in the glaring discrepancy between the growing number of Latinos, African Americans, Asian American/Pacific Islanders and Native Americans and the number of service providers from each of these communities. By the year 2025, they will represent almost 40% of the US population yet they are greatly underrepresented in the number of mental health service providers that are available. 94% of psychologists, 88% of social workers, 92% of psychiatric nurses, 93% of marriage and family therapists and 95% of school psychologists are white (Center for Mental Health Services, 2004).

Culture permeates all aspects of an individual's life and must be taken into consideration when providing services. Failure to understand the importance of culture can result in misdiagnosis leading to inappropriate and poor quality of services. Lack of understanding LGBT issues have very similar consequences. Most mental health professionals do not have an understanding of the experience "coming out" and living as transgender, which often entails rejection from family, friends and loss of employment.

Prevalence of Mental Health Disorders and Service Utilization

Collecting accurate data has been a significant obstacle in obtaining a clear picture of the mental health needs of communities of color. This is due in part to the failure to collect any

demographic data for some of these populations, e.g., continuing to identify American Indians and AAPIs as "others". When information is collected, there is often a failure to disaggregate data, treating each group as a homogeneous population, when in fact, there are wide within group variations.

An example of how this practice presents a skewed picture can be seen by using the percentage of households with an income under $15,000 as a measure of economic stability for AAPIs. If one views AAPIs as a homogenous group, they appear to be doing quite well when compared to the rest of the population. In reality, there is a bimodal distribution with Filipinos, South Asian Indians, and Japanese, at 11.7% 14.1% and 15.6% respectively. At the other end of the economic spectrum, however, are Hmongs with 53.1% of their households having an income of less than $15,000, Cambodians at 40%, Laotians at 32.% and Vietnamese at 26.9%. (U.S. Census, 1999)

There are other factors that impact the availability of accurate data. Many of the most vulnerable populations live in rural communities, are homeless, or incarcerated making it difficult to assess their mental health needs (USDHH 2001). Another reason for the prevalence of inaccurate data can be attributed to either over or under diagnosing an individual because of a failure to understand cultural beliefs, values and behaviors. In addition, prevalence rates also fail to take into consideration the number of individuals who may be seeking services through the primary care system (Lee, 1997; Chung, 2002; Young et al, 2001).

Data that does exist indicates that mental health services are greatly underutilized. Only 8.5% of Latinos/Hispanics meeting DSMIII-R criteria for a psychiatric disorder used mental health services (Vega et al, 1999). This number increases to 15.4% for foreign born and 37.5% for US born Mexican Americans when service providers in the primary health care setting are included, indicating that they enter the system through the primary health care as opposed to the mental health system. According to the Surgeon General's Report, fewer than one in 14 Hispanic Americans with mental disorders, contact mental health care specialists, while fewer than one in 5 contact their primary health care specialist. Fewer than one in 20 immigrants use mental health services while fewer than one in 10 seek help from general health care providers.

The prevalence rates for mental health disorders among African Americans is similar to those of Caucasians (Robins and Regiere, 1991; Kessler, et al., 1994). However, the rates may well be higher since African Americans are overrepresented in psychiatric hospitals, and prisons. In addition, they live in inner city and poor rural areas that are not usually included in samples for household research surveys. The prevalence rates would most likely be higher if they were included in the count (USDHHS, 2001). The percentage of African Americans receiving mental health treatment from any source was about half that for whites (Swartz et al., 1998).

It is very difficult to get accurate picture on AAPIs. Much of this is due to the small number and difficulty disaggregating the data that is available. More often then not, the data is missing altogether as they are listed only as "other". A study that did disaggregated by ethnicity and age, however, found older Asian American women to have one of the highest rates of depression (Browne and Broderick, 1994). Like Latino/Hispanics, depressive

symptoms and other mental health problems may go underreported as AAPIs tend not to present psychological complaints and frequently seek help from primary care physicians (Chung, 2003, Lu, 2003). Kinzie, et al (1997) found that PTSD represents the most common psychiatric disorder, affecting perhaps 50% to 70% of the Southeast Asian refugees in his psychiatric clinic population.

Unlike Asian Americans who immigrated to the United States, Native Hawaiians and other Pacific Islanders did not "arrive" in the United States but were colonized instead. Like Native Americans, their history was dramatically changed when they came in contact with the Western world. For many, the historical and ongoing trauma brought on by oppression and loss of culture has resulted in serious problems including high levels of substance abuse, suicide and depression. They have had their land, their culture and their language taken away. There was a time when it was illegal to speak their language and practice their traditional customs. (Hawaii Advisory Committee to the US Commission on Civil Rights 2001). Native Hawaiians face much the same fate as Native Americans on the mainland. The suicide rate and drug use among Native Hawaiians is higher than for any other ethnic group in Hawaii. The use of methamphetamine or "ice" has become a serious problem on the island (Coalition for Drug Free Hawaii).

American Indians and Alaskan Natives are a particularly vulnerable population. Extreme poverty, generations of cultural genocide and poor health conditions have placed them at great risk for serious mental health problems. According to the Indian Health Service, the death rate from alcoholism is 630% higher than that of the rest of the population with 51.8 deaths per 100,000 compared to the national rates of 7.1 per l00,000; higher rates have also been found for death by accidents (280%), suicide (190%), and homicide (210%) (Rennick 1996). The life expectancy of American Indians and Alaska Natives born today is nearly six years shorter than the American average (Indian Health Service, 2002) and up to 75% of all deaths for American Indians and Alaska Natives is due to violent causes, e.g. unintentional injury, homicide or suicide (Rennick 1996).

It is particularly difficult to get accurate data on the LGBT population as many do not feel safe acknowledging their sexual orientation. On data that is available, the FBI reports in "Hate Crimes Statistics" that 16.4% of reported hate crimes were based on the victim's actual or perceived sexual or gender orientation. Twenty-one of the transgender persons murdered in 2003 were classified as hate crimes. The LGBT population has a higher rate of substance abuse than the general population. In a recent on gay men on the East and West coast found that 66% of gay men used drugs, and 29% used drugs once a week.

Trauma is an issue that is at the heart of many mental health issues. It can both create new emotional problems and exacerbate old wounds. The trauma can come in the form of domestic violence, child abuse, victimization brought on by racism and homophobia, impact of being in a war, violence brought on by gang involvement, drug use, and substance abuse. It can occur in any social economic status but increases in areas of high poverty. Communities of color and LGBT individuals are frequently the target of violent behavior. Without proper treatment, the problems can continue for years.

Over representation in the criminal justice system

African Americans and Hispanics/Latinos have always been are incarcerated in the criminal justice system at a far greater rate than the white population. While African Americans and Latinos only make up 12% and 13% of the total adult population respectively, approximately 40% of all jail inmates were African American and another 15% were Latino (Bureau of Justice Statistics, 2002).

The Bureau of Justice Statistics (Beck, Karberg and Harrison, 2002) estimated that 12% of African American men ages 20 to 34 were in jail or prison in 2001 as compared to less than 2% of Caucasian men in the same age group. Female incarceration rates, although significantly lower than male rates, reveal similar racial and ethnic disparities. African Americans were three times more likely than Hispanic females and almost six times more likely than white females to be incarcerated in 2001. Services in the prison system is all but non-existent. According to the Bureau of Justice, 16% of those in prison have mental health problems and of those, seventy five percent are there for nonviolent offenses.

Recovery Within Diverse Populations

Recovery must involve the whole person. This means mentally, emotionally, physically and spiritually. It means addressing job training, education, health issues and decent and affordable housing. Historically communities of color have viewed the individual from a holistic perspective. This involves the use of traditional healers, acupuncture, ayurvedic medicine, herbal medicine, meditation, *ho'oponopono, morita, naikan,* t'ai chi ch'uan, yoga, and Zen (Pukui, et al. 1972, Lee, 1997, Kendziora et al, 2001, Hays, 2001, Marsella, et al, in press). The concept of splitting the mind and body is foreign and is counterproductive to the healing process. There are those who are turning more and more to the use of traditional healers to help with problems that are viewed as psychological in nature (Jilek, 1994).

Perceived benefit is a major factor in influencing the decision to use CAM (Russinova et al, 2002). It is interesting to note that complementary and alternative medicine (CAM) is growing in popularity among whites with more education who, unhappy with the Western approach, are beginning to see the effectiveness of a holistic approach practiced by non-Westerns (Barnes, et al 2004). Communities of color may experience the opposite, the more acculturated a person is, the less likely they are to use traditional methods of healing. This may be reflective of being influenced by the Western education system that separates the mind and body and has only recently giving credence to CAM methods. It also reflects an ambivalence among persons of color who fear being seen as "too ethnic".

Programs that have been effective in implementing a recovery model meet the needs of the consumer at all levels. When asked what was helpful in their road to recovery, consumers said they needed to feel respected, understood, wanted someone who knew about their culture, spoke their language, was familiar with their community, helped them get a job and job training, helped them receive health services, English classes, did not abandon them when things got rough, gave them hope, and respected their spirituality, however it was defined (NAAPIMHA, 2002). For communities of color, spirituality plays an important

role and may or may not involve an organized religion. It could be a belief in God, a belief in a higher power, respecting one's ancestors, or a belief in the spirit world.

The recovery model emphasizes the fact that individuals with serious emotional/ behavioral problems are capable of being productive members of society, that there is life after mental illness and substance use disorder and restoring self esteem is an essential part of recovery (Fisher, 1999, Provencher, et al 2002; Deegan, 2003; *SF Wellness & Recovery Forum, 2004*). The focus on restoring self-esteem and attaining a meaningful role in society is of particular importance in working with diverse populations. Many are isolated and disenfranchised due to cultural and linguistic barriers, biases and prejudices that bar them from participating fully in society. In this case, *fully* refers to being able to participate as one is, not as society prescribes. This means not having to worry how a person's ethnic background makes one automatically suspect to involvement with unacceptable or illegal behavior, how being foreign born makes one less patriotic or trustworthy, how having a strong accent or having limited English capabilities makes an individual less intelligent or competent, how having moral judgment placed on an individual because of their sexual orientation. Unfortunately, racism, homophobia and xenophobia are alive and well within all our communities.

A person of color or a LGBT individual with serious mental health problems must deal with the biases towards both their ethnicity/sexual orientation and their mental health/co-occurring disorder. The need to belong and feel accepted is a fundamental human need. For some, the denial of one's true self is a desperate attempt to survive, the need to "pass" in order to fit in. Gene Deegan (2003) describes how he tried to pass as "normal", how he tried to hide his mental illness. "*I'd internalized the old stereotypes about mental illness... I feared losing my identity, hopes and dreams. I hid them at all costs. Deep down I stigmatized myself" (pg 369).* Passing for a person of color may come in the form of denying one's racial/ethnic heritage. For a LGBT person, it is passing as "straight". Being disingenuous about one's true identity places a heavy burden on an individual and can take a toll on a person's emotional well being.

In San Francisco, the City and County Dept of Public, Health Wellness and Recovery group outlined the design for culturally appropriate services that address recovery for co-occurring disorders. In their March, 2004 meeting, they stressed the importance of involving consumers at all levels in the system of care and proposed the following:

- ❑ Involvement and empowerment in the planning of their individual care and services
- ❑ Recognition of their strengths and ability to self-manage their illness
- ❑ Recognition of their unique individual capability to help fellow consumers
- ❑ Establish self-help and consumer rune programs and agencies
- ❑ Promotion of consumers in leadership roles
- ❑ Hiring of consumers

In keeping with an integrated approach, the Wellness-Recovery perspective addresses co-occurring disorders through the following principles:

- ❑ Any door is the right door
- ❑ Dual diagnosis is the expectation, not the exception
- ❑ All programs will be dual-diagnosis capable

- ❑ Both disorders will be treated and addressed
- ❑ Integrated treatment will be the standard of practice
- ❑ Not all dually-diagnosed clients are the same
- ❑ Hope will be instilled, the inner strengths of the client recognized
- ❑ Peer recovery model will be promoted throughout the system
- ❑ Clients will be empowered and respected

Examples of Recovery Models in Diverse Communities

The Hire-ability program at RAMS, Inc. in San Francisco Established in 1974, RAMS, Inc. is the one of the oldest and most well established community based agencies in the country to provide mental health services to the diverse AAPI communities. RAMS developed the Café Phoenix which has been written up in several newspapers that celebrates the Café's success. The San Francisco Chronicle wrote (June 7, 2003) "At Café Phoenix, the tidy new café on the southeast side of Potrero Hill, you'll find three things on the menu, and the most important one isn't written down. First, there's the gourmet food... ... Then there are the prices so low you have to check the map to make sure you're still in SF... And then there is the offering not written: hope for the people who work there, folks with mental problems. With the exception of the chef, it is staffed entirely by mentally ill people who are either homeless or at risk of becoming that way. For Jeff, diagnosed with schizophrenia, it is his way out "All we need is a little help.'"

The Los Angeles Times (July 1, 2003) wrote "As the lunch rush packs a tiny restaurant here, he stands timidly behind the cash register, dressed in his red apron, fighting off the doubts that he will be able to keep all these orders straight. He avoids eye contact, convinced that every stranger is staring at him, laughing and assuming that he's somehow stupid when he knows that he is a very smart person who happens to be mentally ill. For most of his 33 years, Flannery has suffered from depression. The simple act of showing up for work can trigger a debilitating fright. And so, to rejoin the job force, he has placed his faith in Café Phoenix. At the Phoenix, almost all of the employees battle mental illness – from delusions and schizophrenia to bipolar disorder to paranoia. To say the least, Café Phoenix is no ordinary restaurant. Workers grapple with their problems under the watchful eyes of counselors while dealing with demanding customers, negotiating kitchen politics and juggling the never-ending flow of orders.

Huki Like Kakou A Chance to Work can be loosely translated as cooperation. It is a program of Hale Na'au Pono at the Wai'anae Community Mental Health Center on Oahu. Located on the most economically disadvantaged are of the island, it works with individuals with serious mental illness to help them gain independence. Most never had a job and saw their future as hopeless. *Huki Like Kakou* follows the tradition of the *hukilau*, a style of fishing in which the whole village joined together to form a large circle to gather fish. The catch is then shared by everyone in the village as all are viewed as having a part in the gathering of the fish. The pulling together is grounded in cultural concept of *aloha*, of respect for each other. The program is founded on the principle "work is medicine", "I work – I eat" and "in sharing, there is enough for all".

At Level I, they begin by identify their heritage and cultural roots. They are introduced to the *ahupua* system, a land division that extends from the mountains to the sea and provided their ancestors with their spirituality, their respect for the environment, the importance of water, conservation and the family. At Level II, trainees learn how to safely use equipment that will be used to build the tanks that will hold the fish. Agriculture and aquaculture are introduce with hands on activities in the taro garden, tilling the area, preparing the plot for panting, instilling irrigation systems and learning how to grow vegetables and other plants. At the advanced stage, Level III, the consumers actually prepare the tanks, learn how to take care of the fish, manage the water system, order supplies to build the tanks and in general run the project. They can take pride in the fact that are seen as an equal partner at each step of the process. It is a project that truly feeds the stomach as well as the soul.

Helping Hands Project, an urban based project in Tacoma Washington incorporates the use of traditional tribal healing in their treatment planning and provision of services. Since the project serves an intertribal population, they have also developed and implemented a training seminar for Native and non-Native service providers which calls upon widely recognized traditional healers (from both the U.S. and Canada) to recognize the need to involve the extended family support network, clarify the value differences between the service providers and the families seeking help, and to provide a comparison of western based psychological treatment and a tribal specific healing philosophy. One example of the comparisons provided in their training is the "story" of a young Blackfeet woman (Running Wolf & Running Wolf, 2004) who had been attacked by a grizzly bear. She shared her experience of being "treated" for post traumatic stress disorder by a Caucasian psychologist (utilizing a cognitive behavioral theoretical orientation) and contrasted this approach with participating in traditional Blackfeet spiritual ceremonies (no direct questions were asked about her attack and a "re-framing" of the traumatic experience as being selected and "gifted" with a spiritual experience and as an act of courage).

Hearts & Ears, Inc. is a consumer group for and by LGBT people located in Baltimore City. It began in November 1998 as a weekly support group as part of a psychosocial program. It now has a large drop in center in an apartment building. Its mission is to support, advocate, educate, and train consumers at the center. Ultimately, its goal is for group consumers to utilize the public mental health systems less and societal supports more. Over 51% of its Board of Directors identify as consumers, survivors or in recovery. Most of its consumers use the public mental health systems and receive entitlements. Many attend day programs, vocational rehabilitation centers, work or school. They span all races, ethnicities, religions and abilities, and all sexual and gender orientations. In general, there is the freedom to be different and to disagree with others, yet feel comfortable and accepted for their selves.

Its program's include a large drop-in center located in a residential building. Decorated by group members to bring gay culture and a piece of their selves into its community, its banners, art contributions, posters of GLB men and women, and rainbows decorate the walls. LGBT literature, local gay newsletters, information on LGBT health issues and resources are displayed or easily available. In three weekly support groups, issues include dealing with homophobic remarks, managing sexual side affects of medication, , feeling alienated from the LGBT community, and a plethora of other topics that effect LGBT people with serious mental illness. Consumers fear the open hostility towards LGBT people that is prevalent on television and in newspapers, expressed by heterosexual peers in day

programs, and passively reinforced by staff by their failure to address it. Some have been the victims of hate crimes in the mental health systems and in other areas of their lives. As peers, they have the ability to empathize and help cushion the emotional impact of the dual discrimination that they experience. Many consumers have a community of folks who can understand them for the first time. A thirty three year old gay male said, "Hearts & Ears meets the needs that I have to be around other gay people. Being gay is such a big part of your history. It is a release to talk to others who know where you are coming from."

Recovery is a complex concept that should remain fluid over time. However, for LGBT people to be treated successfully in the mental health systems it is necessary for providers to recognize that LGBT people are in their programs. "Most mental health providers do not recognize the existence of LGBT people in their programs who don't look or act like their stereotype of a sexual or gender minority. The consumer who reaches out to them for help has been told they are *really* heterosexual ".

Recommendations

1. *Workforce development* - in an effort to reduce the disparities in quality of care, there is a great need to improve the workforce. This means increasing the number of bicultural and bilingual staff who have been properly trained to provide culturally competent services. This also means developing and implementing new training curricula that take into consideration cultural factors that impact diverse populations. The training must be strength based and follow a recovery model
2. *Reimbursement for services* – there needs to be better reimbursement for the provision of complimentary and alternative medicine and other intervention strategies that reflect the traditions of communities of color. This also includes use of interpreters and para-professionals who have been properly trained.
3. *Anti stigma and anti racism campaign* – establish policies and practices that do not tolerate oppression of any kind. Recovery must occur in an atmosphere that is tolerant of and accepts diversity. The public also needs to be educated on mental health issues in general in an effort to reduce the stigma surrounding mental health issues
4. *Data collection and research* – there continues to be a need to collect data that accurately reflects the mental health needs of diverse communities. This includes disaggregating data within each of the major ethnic groups
5. *integration of mental health, primary health and substance use disordered treatments* – a true recovery model does not separate the mind from the body and views the individual from all systems. It also involves a holistic approach that incorporates employment, housing, language acquisition, and health
6. *Consumer involvement* – more consumer advocates need to be trained. Their voice is critical to improving quality of care. There is a real danger of burn out for the few who are continuously asked to speak on behalf of all consumers. Involvement of consumers is in and of itself part of the healing and recovery process.

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