

*Developing Systems and Services
that Support People
in Wellness and Recovery*

A Primer for Holding Informed Discussions



Written by the
California Association of Social Rehabilitation Agencies

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**Developing
Systems and Services that Support
People in Recovery**

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Preface

The passage of the Mental Health Services Act¹ in California provides a once-in-a-lifetime opportunity to access a significant amount of resources to provide additional community-based services that are not yet in place in the California mental health system. It asserts that the mission of public mental health services in California is to improve the lives of people diagnosed with mental illness, not just treat the symptoms of mental illness. It also begins to articulate a set of agreed upon principles and services to address quality of life and are based upon rehabilitation and recovery-oriented practices.

It is the vision of the Mental Health Services Act "to promote concepts key to the recovery for individuals who have mental illness; hope, personal empowerment, respect, social connections, self-responsibility, and self-determination."

Our challenge is to make the vision of recovery real in the work we do. To help us achieve this vision, this primer has been created to provide a sense of the landscape. It includes examples of activities and strategies that have been found to be helpful to counties, agencies and program providers.

This primer is intended to be a living document. It is not meant to be the only way to approach a recovery-oriented system. It is our hope that you will use it as a jumping off point for dialogue with community members. In addition, that out of that dialogue strategies will arise that are congruent with recovery-oriented goals and principles, reflective of the unique individual, and cultural needs of your community.

In this report, we will review the concept of recovery and various meanings reflected in the use of the term, define the guiding principles of a recovery-oriented mental health system and describe the story of the recovery movement in California. We then present a look at Best Practices focusing on system issues, workforce development, services, and community development.



¹ The Mental Health Services Act was passed by California voters as Proposition 63 in November 2004

I. Introduction

A. **Intended Audience**

This primer is about how to figure out how to transform public mental health services from treating and reducing symptoms to helping to enhance the quality of life of persons living with serious mental health issues. To see (and think of) people who require services as normal people working to overcome whatever dis-ease troubles them.

We assume that most readers are already committed to such a journey. Therefore, we do not attempt to convince the audience of the worthiness of the effort. Instead, we attempt to provide a foundation of values and principles upon which a local conversation and design can be built. Our common commitment to the vision and the guiding values and principles will allow us to transcend our differences and to identify our respective contributions. To quote a wise woman, “it takes a village.”

B. **How this Primer was Prepared**

This is the result of love and commitment of the members of the California Wellness Recovery Task Force who have been meeting to support each other and keep the ‘recovery’ vision alive for ten years. It was written in several phases over a period of two years. The first phase involved a review of the literature and the historical work of the CA Wellness Recovery Task force. This resulted in an outline for the primer and the development of a first draft. The second phase of production involved responding to the feedback of the many people who read the draft version, including recognized experts on the various topics. This version is the result of the conversations thus far.

**“People
First”
language**

C. **A Word About Language**

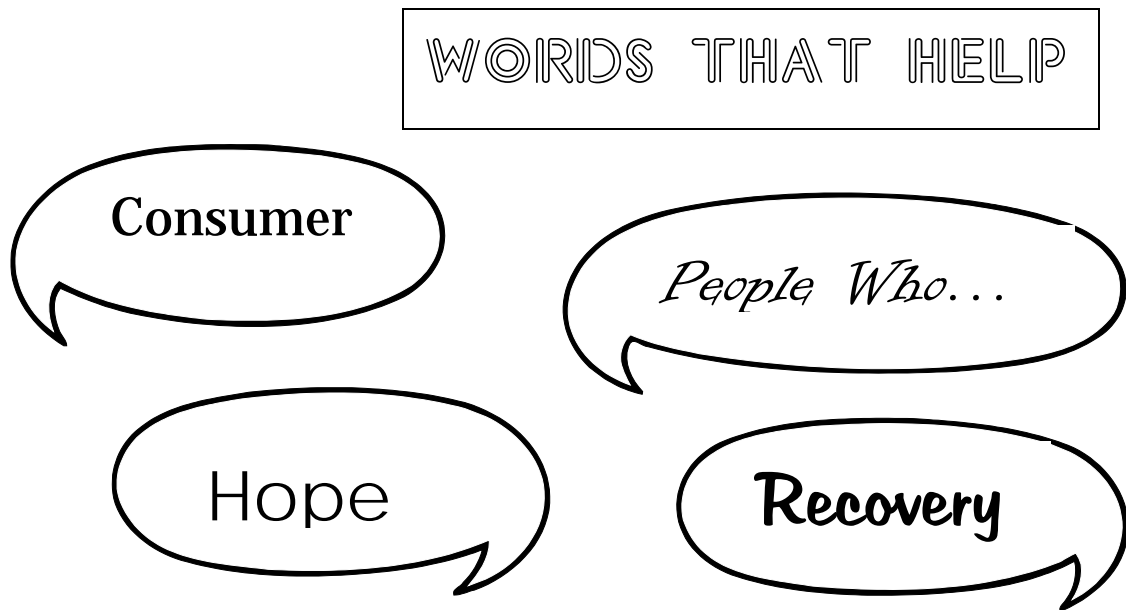
The use of language conveys and reflects the way that we think about the world around us. It is vital that we choose terminology that supports the concepts and reality of recovery.

Throughout this document, we use the term “people with a psychiatric disability” rather than labels like bipolar, etc. The use of people first language conveys the concept that first, and foremost, we are people and our disability is not who we are. It is through social supports and reasonable

accommodations that people with psychiatric disabilities are able to recover their meaningful roles in the community of their choice.

Another term used is “consumers,” which emphasizes that we choose services that are useful and meaningful to us, and in that way influences the mental health marketplace.

In all cases, we recommend honoring the “person-first” principle and when in doubt, you can always ask the person’s preference. As our understanding of recovery evolves, old terms may become limiting and will need to be replaced with ones that more clearly convey our deeper understanding of ourselves.



II. Wellness and Recovery

A. What Is Recovery?

While there are many definitions of recovery, ultimately recovery is defined by the individual consumer and consists of basic principles such as having hope, choice, self-determination, and personal responsibility. Recovery also involves finding one's niche or gift in life.

Pat Deegan² (1995) eloquently describes recovery in the following terms:

The concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings. Like a pebble tossed into the center of a still pool, this simple fact radiates in ever-larger ripples until every corner of academic and applied mental health science and clinical practice are affected.

Those of us who have been diagnosed are not objects to be acted upon, we are fully human subjects who can act and in acting, change our situation. We are human beings and we can speak for ourselves. We have a voice and we can learn to use it. We have a right to be heard and listened to. We can become self-determining. We can take a stand toward what is distressing us and need not be passive victims of an illness. We can become experts in our own journey of recovery. The goal of recovery is not to get mainstreamed. We don't want to be mainstreamed. We say let the mainstream become a wide stream that has room for all of us and leaves no one stranded on the fringes."

Bill Anthony³ (1993) takes another approach to recovery:

Recovery is a process and experience that we all share. People face the challenge of recovery when they experience the crises of life, such as the death of a loved one, divorce, physical disabilities, and serious mental illness.

² Dr. Patricia Deegan has authored a number of articles and publications relevant to psychiatric recovery.

³ William Anthony is Director of the Center for Psychiatric Rehabilitation at Boston University.

Successful recovery does not change the fact that the experience has occurred, that the effects are still present, and that one's life has changed forever.

Rather, successful recovery means that the person has changed, and that the meaning of these events to the person has also changed. They are no longer the primary focus of the person's life.

Amy Long, a person in recovery who works closely with Pat Deegan, provided the following take on what recovery is, or is not, at the CASRA conference in Culver City (November 5, 1999).

<i>Recovery</i>	
<i>is not about...</i>	<i>is about...</i>
<i>Having no symptoms</i>	<i>Managing symptoms</i>
<i>Work</i>	<i>Meaningful activity</i>
<i>Level of functioning</i>	<i>Quality of life</i>
<i>Maintenance and stabilization</i>	<i>Self-sufficiency and independence</i>
<i>Medication compliance</i>	<i>Lowest dosage necessary</i>
<i>Coercion and compliance</i>	<i>Collaboration and having a voice</i>
<i>Motivation</i>	<i>Rekindling hope</i>

Lastly, Priscilla Ridgeway, formerly with the University of the Kansas School of Social Welfare and now with Duke University, offers this comparison of the principles of the emerging recovery paradigm versus the “old think” – deficiency or chronicity paradigm.

Recovery Paradigm vs. Chronicity Paradigm

<i>Active Growth</i>	<i>Stabilization/ Maintenance</i>
<i>Hope, Realistic Optimism Plasticity</i>	<i>“Broken Brain”</i>
<i>Unique Identity “Person with a Disability”</i>	<i>Diagnosis/ CMI/ SPMI</i>
<i>Strengths/ Resilience/ Self-Righting Capacity</i>	<i>Pathology/ Deficits Vulnerabilities</i>
<i>Integrated Bio-Psychosocial-Spiritual Holism</i>	<i>Biological vs Psychosocial vs Oppression Models</i>
<i>Consumer Driven Self-Determination Self-Help/ Experiential Wisdom</i>	<i>Professional Authority Paternalism Expert Services</i>
<i>Empowerment</i>	<i>Coercion</i>
<i>Self-Efficacy/ Agency/ Self-Sufficiency</i>	<i>Helplessness/ Passivity/ Adaptive Dependency</i>
<i>Community Integration Access/ Accommodations</i>	<i>Social Segregation in Deviancy Amplifying Artificial Settings</i>
<i>Normative Role Accumulation (Tenant, Employee, Friend, etc)</i>	<i>Recipient as “Full Time Job”</i>
<i>Asset Building</i>	<i>Resource Limitations/ Poverty</i>

B. Why "Recovery?"

People have always recovered from psychiatric disabilities. Even those individuals who appear to be experiencing extreme difficulties over a long period continue to have the potential to improve.

We now know that recovery from the condition known as mental illness is a fact. First-person accounts by consumers, empirical research and the outcomes of social rehabilitation approaches have converged to provide the evidence.

Writings of Consumers. Culminating in the decade of the 1980s, consumers have been writing about their own and their colleagues' recovery. These first person narratives describe a process that is deeply personal and reflects the unique values and perspectives of the individual. Recovery involves discovering new meaning and purpose in one's life that transcends a mental health diagnosis and the catastrophic effects of a psychiatric disability.

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.

Sylvia Caras ~ California

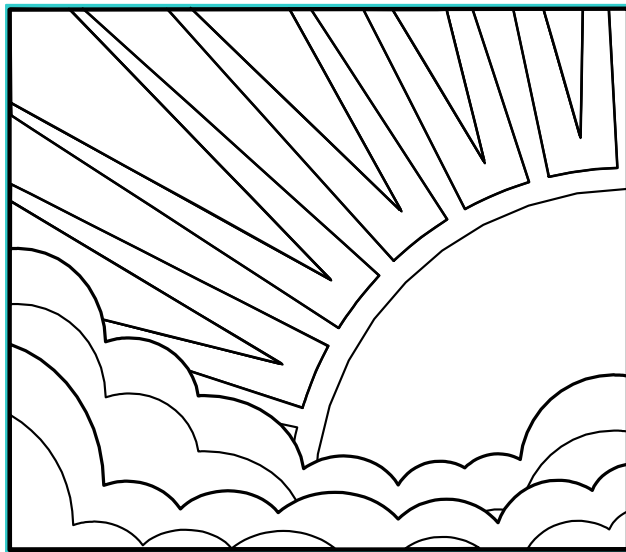
Empirical Work of Harding and Associates. A review of the long-term studies completed by Harding and her colleagues maintain that a deteriorating course for severe mental illness is not the norm. *"The possible causes of chronicity may be viewed as having less to do with the disorder and more to do with the myriad of environmental factors interacting with the person and the illness"* (Harding, Zubin, & Strauss, 1987, p. 483).⁴ These studies have provided the factual basis for reformulating our assumptions about the course of severe mental illness and also the importance of addressing the social and community context in which consumers find themselves in.

Social Rehabilitation Approach. The last thirty years have also seen the emergence of the philosophy and principles of social rehabilitation (also referred to as psychosocial rehabilitation) and the recognition of its

⁴ Harding, C. et al (1987). The Vermont Longitudinal study of persons with severe mental illness, I. Methodology, study sample, and overall status 32 years later. *American Journal of Psychiatry*, 144:718-728.

importance to inform systems and services. One example is the work of Harding (Desisto, et al., 1995)⁵ that involved comparing the long-term outcomes of people with psychiatric disabilities served in two different systems in two separate states. This study concluded that the differences in recovery outcome were due to the presence, or lack thereof, of a rehabilitation orientation.

The growing literature on the advantage of providing psychosocial rehabilitation services to people in recovery from mental illness is summarized in the recent New Freedom Commission report. It urged the mental health field to “move forward as quickly and efficiently as possible to achieve a more competent and expanded workforce necessary to ensure the full opportunity for recovery, resiliency, and wellness for all Americans with mental illnesses.”⁶



⁵DeSisto, M. J., Harding, C. M., McCormick, R. V., Ashikaga, T., & Brooks, G. W. (1995a). The Maine and Vermont three-decade studies of serious mental illness; I. Matched comparisons of cross-sectional outcome. *British Journal of Psychiatry*, 167(3), 331-338.

and

DeSisto, M. J., Harding, C. M., McCormick, R. V., Ashikaga, T., & Brooks, G. W. (1995b). The Maine and Vermont three-decade studies of serious mental illness; II. Longitudinal course comparisons. *British Journal of Psychiatry*, 167(3), 338-341.

⁶ Achieving the Promise: Transforming Mental Health Care in America, (2003). New Freedom Commission.

Resources

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11-23.

Carpenter, J. (2002). Mental health recovery paradigm: Implications for health and social work. *Social Work Journal* 27(2).

Anthony, W. (2000). Recovery as policy in mental health services: Strategies emerging from state. *Psychiatric Rehabilitation Journal*. [spring]

Deegan, P. E. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 19(3), 92-97. Available at www.bu.edu/cpr/repository/articles/deegan1996.pdf

DeSisto, M. J., Harding, C. M., McCormisck, R. V., Ashikaga, T., & Brooks, G. W. (1995a). The Maine and Vermont three-decade studies of serious mental illness: I. Matched comparisons of cross-sectional outcomes. *British Journal of Psychiatry*, 167(3) 331-338.

DeSisto, M. J., Harding, C. M., McCormisck, R. V., Ashikaga, T., & Brooks, G. W. (1995b). The Maine and Vermont three-decade studies of serious mental illness: II. Matched comparisons of cross-sectional outcomes. *British Journal of Psychiatry*, 167(3) 338-341.

Ralph, R. O. (2000). *Review of recovery literature: A synthesis of a sample of recovery literature* University of Southern Maine, Edmund S. Muskie School of Public Service. Available at http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/ralphrecovweb.pdf



C. Concepts of Recovery

For many people, the goal of mental health recovery may be full integration into all aspects of community life. Recovery is a personal journey, and many have found the four stages described by Mark Ragins, M.D. a useful conceptual framework. The idea of stages is built upon the work of Dr. Kubler-Ross who identified a series of stages of the grieving process. They are not sequential but dynamic as an individual may move in, and out, throughout their journey.

Hope. Recovery begins with a positive vision of the future. Hope is highly motivating when it takes form as a real, and reasonable, image of what life can look like. Individuals need to see possibilities – getting a job, earning a diploma, having an apartment – before they can make changes and take steps forward. Seeing real opportunities facilitates hope.

Having some hope is crucial to recovery; none of us would strive if we believed it was 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.

Esso Leete ~ Denver Colorado

Empowerment. To move ahead, individuals need a sense of their capabilities. Hope needs to be focused on what they can do for themselves. To be empowered, they need access to information and the opportunity to make their own choices. We also need to quit disempowering people by presuming they lack the capacity to make their own choice.



**Pathways
To
Wellness**

Self-responsibility. As individuals move toward recovery, they realize they need to be responsible for their own lives. This comes with trying new things, learning from mistakes and trying again. We encourage individuals to take risks, such as living independently, applying for a job, enrolling in college, or asking someone out for a date.

A meaningful role (or niche) in life. To recover, individuals must have a purpose in their lives separate from their diagnosis. They need to apply newly acquired traits such as hopefulness, confidence, and self-responsibility to “normal” roles such as employee, neighbor, graduate, or volunteer. Meaningful roles help people with psychiatric disabilities “get a life.”

D. Recovery as an Outcome and Recovery as a Process

Recovery is diversely referred to as a process, an outlook, a vision, and a guiding principle.

William A. Anthony described recovery as a guiding vision that *"pulls the field of services into the future. A vision is not reflective of what we are currently achieving, but of what we hope for and dream of achieving. Visionary thinking does not raise unrealistic expectations."*⁷

Many individuals have experienced recovery as a process that is non-linear with peaks and plateaus. While our health improves, we must continue to practice those things that promote our recovery. This perspective may provide some hope during a process that can be very long and difficult.

According to Dr. Anthony, *"a person with mental illness can recover even though the illness is not 'cured' [Recovery] is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."*

The Empowerment Model of Recovery described by the National Empowerment Center supports the concept that recovery, like an outcome or goal, is achievable (www.power2u.org). This perspective challenges the belief that mental illness is a permanent condition. Survivors, including Dr. Fisher, have described the repeated message from providers that "if you're no longer mentally ill, it's because you were misdiagnosed in the first place."⁸ The belief that you can recover is vital in the recovery process.

This perspective conflicts with the assumption that having a psychiatric or mental disability must be accommodated rather than cured. Others view recovery not as returning to a previous state or condition but developing and growing beyond the point where they had reached crisis previously.

This primer suggests that whether recovery is a destination or a journey, it is the lived experience and the support of others that is important.

⁷ *Mental Health; A Report of the Surgeon General*. (1999) Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁸ Fisher, Daniel "A New Vision of Recovery; People can fully recover from mental illness; it's not a life-long process" www.power2u.org

E. Philosophical Principles and Values

Choice. A recovery-oriented system promotes consumer choice about their services. Consumer choice requires that consumers have options to choose from, information about those options, and the liberty to choose or not to choose services.

Self-determination. Self-determination means that consumers have the freedom to determine their own course of action and to take responsibility for the results of that action. Consumers and their expressed needs come first. Services are provided based on the individuals' own goals and decision-making.

Client involvement. Consumers and their families are unique and essential participants in providing advocacy, services, education, and training. Consumers must play an active role in the system designed to help them cope with their illness and readjust to community life.

Flexibility. Programs and services must be prepared to change in order to address the changing needs of the individual. Individuals must perceive and believe that they have a genuine opportunity to question and change elements of the services they receive. The natural consequences or outcomes of various choices are opportunities for growth and learning.

People generally will rise to the occasion and accomplish what is expected of them. If forced to choose, it is better to raise the bar of expectations rather than to lower it.

Community Integration. Mental health recovery does not happen in isolation but includes full integration and participation in all aspects of community life. Persons with psychiatric disabilities may be described as being in the community, but not of it. Living, working, education, finance, spiritual, and social goals should be addressed. These areas often form the core of an individual's ability to participate in community life.

Resources

<p>Ragins, Mark. (1998). <i>The Road to Recovery</i> is available from The Village ISA at: http://www.village-isa.org/Village%20Writings/writings_hp.htm</p>
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F. Culture-Centered Recovery

The journey of recovery involved the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. In California, we promote the concept of "culture-centered" recovery to reflect our growing understanding of the critical role that culture plays in creating the context for a durable client recovery. A culture-centered approach seeks to understand a person in recovery in their cultural context. It does so by viewing disability issues and recovery principles and experience in the individual's cultural context, beginning with the local community and moving out to North American and international contexts.

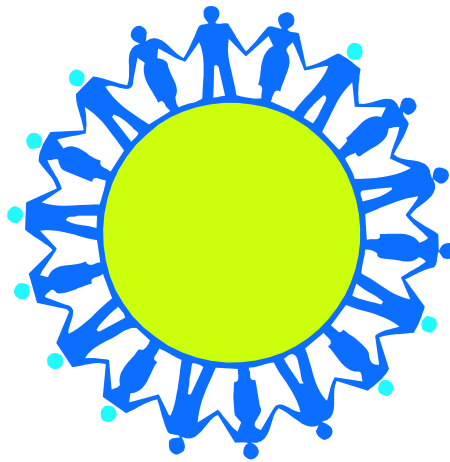
Culture-centered recovery begins with the person's culture of origin, including the recognition of sources of strength and resilience that the client brings from that heritage. It moves to embrace client culture—that set of values, beliefs, perceptions, and language—that are the product of each client's experience with a psychiatric disability, the mental health system, and the "cultural teachers" they encounter in both professional and client cultures that assist them with their recovery. Recovery comes to be viewed as a change in one's self, a change in one's cultural identity as persons in recovery negotiate these cultural settings to create a "self in recovery."

A culture-centered approach is a competency based one. Culture-centered recovery views cultural competence as *"a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables that system, agency or those professionals to work effectively in cross-cultural settings."*⁹ As such, cultural competence is a developmental process, a product of the developing competencies of individual practitioners, clients, and the system at large. A culture-centered approach to recovery seeks to build on existing practitioner competencies that are based on contemporary theories of medical, psychological, social work, etc. It seeks to strengthen these theories and practices by interpreting them in the client's cultural context as collaborative choices in the recovery process. A culture-centered approach seeks to have practitioners develop competencies in three broad areas: attitudes/beliefs, knowledge, and skills. Equally critical is the development of client competencies from their experience of peer support in the context of client culture. A number of instruments have been developed to measure multicultural competence.

⁹ Cross, T., Bazron, B., Dennis, K. W. Isaacs, M. R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed (vol 1)*. Washington, DC: Georgetown Univ. Child Development Center.

The California Brief Multicultural Competence Scale is one such resource that can be used to both measure multicultural competence and plan for competencies to be developed.

There is another aspect to the cultural competence conversation. Most mental health programs are primarily designed around the idea of *personal preparation* - helping to increase the capacity of the person receiving services to participate in community life. We believe that it is also important to focus on *community preparation* - enhancing the community's capacity to include all citizens in community life. Thus, a service system that is both culture-centered and recovery oriented seeks to enhance the cultural competence of mental health service providers and to bring resources to indigenous groups already serving their community.



Resources

CA Mental Health Planning Council. (2003). *California Mental Health Master Plan: A vision for California*. Sacramento, Ca: Author. Available at <http://www.dmh.ca.gov/MHPC/masterplan.asp>

Pedersen, Paul (1993). *Culture-centered Counseling Intervention: Striving for Accuracy*. Thousand Oaks, Ca: Sage Publications.

The California Brief Multicultural Competence Scale. Contact Glenn Gamst, University of LaVerne (gamstg@ulv.edu)

U. S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity* [Supplement to Mental health: a report of the Surgeon General]. Available at <http://mentalhealth.samhsa.gov/cre/default.asp>

G. Recovery, Wellness and Resilience

The use of the term recovery has its drawbacks. Since the term recovery was first used in the addiction field, there can be confusion when it is used in a mental health context. Some persons with psychiatric disabilities feel the use of the term recovery implies that there is something wrong with them and does not acknowledge the impact of abuse or other environmental difficulties. Others believe the term implies a going back to something when, in fact, their sense is of going towards something.

In contrast, the concept of wellness is a positive approach to life and health that maximizes the individual's potential. It implies a movement towards health rather than away from illness. Wellness implies balance, harmony and health. The mind body connection is emphasized and the person is empowered by choice.

Wellness is obtained through lifestyle rather than taking pills. Since you do not have to be sick to seek wellness, there are fewer stigmas attached to the term.

Resilience is the process of adapting in the face of adversity, trauma, tragedy, threats, and/or other significant stressors. While emotional pain and sadness are not avoided, it means "bouncing back" from difficult experiences. Resilience involves behaviors, thoughts, and actions that can be learned and developed in anyone.

It would then follow that we could train people to be resilient and reduce the likelihood of them succumbing to emotional distress. In this way, people could be trained to be well or emphasizing focusing on their strengths rather than symptoms.

Resources

Institute for the Study of Human Resilience, Boston University.
<http://www.bu.edu/resilience/>

The Road to Resilience is a self-help brochure geared toward adults produced by the Help Center of the American Psychological Association.
<http://www.apahelpcenter.org/featuredtopics/feature.php?id=6>

The importance of 'resilience' in helping people cope with adversity presents a good overview of the pioneers in resilience research and the progression of thought on the concept. <http://www.onlineopinion.com.au/view.asp?article=1847>

H. Wellness and Recovery Initiatives in California

It might be observed that the wellness and recovery movement in California has its roots in the mid-60s when the first halfway houses were developed to provide a post-hospitalization, community-based rehabilitation setting. The lessons learned in these programs led to the development of the first residential alternative to hospitalization (1971) and the first supportive housing programs.

In 1976, Mental Health Consumer Concerns became the first consumer-run organization in California (second in the nation). Begun as a peer support and self-help agency it currently provides patients rights services in three northern California counties.

The Community Residential Treatment Systems Act (CRTS, 1978) was the first legislative initiative in the nation to articulate a vision of a community mental health system based upon rehabilitation and community integration principles.

The CRTS Act promoted the development of community-based, rehabilitation-oriented alternatives to hospital and skilled nursing settings noting that many of the problems faced by consumers were not addressed and even exacerbated in these settings. The Act also encouraged attention to consumer vocational goals and was the first to encourage hiring consumers as mental health staff.

In the mid-80's, the Community Support Systems for Homeless Act and the Community Vocational Treatment Systems Act (1985) promoted integrated service centers to help consumers who were homeless and attempted to address the continuing resistance of the mental health community to encourage and support consumer education and employment goals.

The Integrated Services Agencies (1988) initiative combined the need for comprehensive and integrated services designed to address the quality of life of persons diagnosed with mental illness. The Homeless Adult Program (AB 34/2034) built on the success of the Integrated Services Agency with a focus on outreach and engagement to those who were homeless or jailed.

Implementation of the Rehabilitation option under Medicaid and the realignment of funding for public mental both furthered the movement to a rehabilitation and recovery-oriented system. The Rehabilitation option provided a fiscal incentive (in the form of federal financial participation) to

maintain rehabilitation services in tight financial times. And Realignment removed the fiscal benefit to Counties when placing consumers in state hospitals and skilled nursing facilities by transferring the responsibility to pay for the cost of institutionalizing clients.

In the last five years, a statewide movement to promote wellness and recovery as the goal of mental health services in California has fully emerged.

What follows is a brief chronology of how a wellness and recovery-oriented vision was promoted within the broader mental health community:

FY 1995-2000

- ***Contra Costa County established California's first wellness/recovery task force and sponsored the first wellness/recovery conference***

Because of this conference, Contra Costa, Solano, Alameda and Stanislaus Counties decided to develop ways to learn and build upon one another's wellness and recovery-oriented efforts. From the onset, it was evident that meaningful collaboration among consumers, families, and providers would be necessary to carry out these efforts.

Their first project was to conduct focus groups with various consumer/family groups and ethnic communities to understand how people from various backgrounds understand the concept of recovery.

[It should be noted that there was significant consensus across cultural groups on the concept of recovery and the importance of wellness. However, the concept of wellness was most often framed in terms reflective of the cultural values and norms of the group.]

- ***California Wellness/Recovery Task Force is formed***

Consumers, family members, and providers from Contra Costa, Solano, and Alameda provided the initial membership of the group. Focus group research was completed on attitudes towards recovery and the outcomes were used to design statewide dialogues on Recovery, be conducted during FY2000 under the auspices of the California Institute for Mental Health (CIMH).

- ***Wellness Recovery Center concept developed in Stanislaus County***

The WRC concept was designed to serve consumers requiring medication-only services. The program focuses on training consumers and interns to conduct outreach and peer support services.

- ***California Association of Mental Health Director's Association (CMHDA) Adult System of Care Committee develops "Imparting a Vision of Recovery to County Mental Health Directors"***

A bibliography and literature summary on recovery was compiled by the California Wellness and Recovery task force and adapted into a draft of "Recovery Statements" for review and approval of CMHDA.

- ***CMHDA Adult System of Care Partnership Conference***

The theme was recovery and the final "Recovery Statements" were presented.

FY 2001-2002

- ***Regional Recovery Dialogues are held at seventeen sites throughout California***

With the sponsorship of CIMH, the California Wellness and Recovery Task force designed these events to introduce consumers, family members and providers to the promise and reality of recovery from major mental illness. The content included a summary of the research findings debunking the myths about mental illness and introduced a conceptual framework for describing the components of recovery; hope, choice/self-determination, personal responsibility and finding a meaningful role in life.¹⁰

- ***Pathways to Wellness Video***

The California Wellness and Recovery Task force, in collaboration with the California Institute for Mental Health and funding from the CA State Department of Mental Health, produced "Pathways to Wellness." The video features consumers and family members from diverse backgrounds speaking on what 'recovery' means to them.

¹⁰ Adapted from Ragins, Mark. *Road to Recovery*. Available for download <http://www.village-isa.org/Ragin's%20Papers/Road%20to%20Recovery.htm>

- ***Survey of Bay Area County Recovery Initiatives completed***

A survey was designed to identify actions that are supportive of a recovery initiative in the mental health system. Among the items noted:

- *Wellness & Recovery Task Forces exist that are composed of consumers, family members and providers working collaboratively*
- *Mission statements express recovery and enhanced quality of life*
- *Opportunities exist for consumer employment in mental health positions at all levels*
- *There are peer counseling training programs*
- *There is a wellness/recovery center or other consumer-run, drop-in service*
- *There is systematic training for staff and interns at all levels on recovery-oriented principles and practices and supervisory practices that support rehabilitation/recovery-oriented practices*
- *Persons with psychiatric disabilities hold leadership roles within system/state/ agency management*

FY 2003-2004

- ***CA Wellness & Recovery Task Force continues to meet and serve as clearinghouse and "culture bearer" for the vision of a recovery-oriented mental health system***
- ***Bay Area Counties continue regional collaboration***

Consumers, family members and providers meet to develop a work plan to support a regional wellness/recovery vision.

FY 2004

- ***Mental Health Services Act (Proposition 63) is passed***

Culminating the work and increased knowledge over a thirty-five year period, California voters passed the MHSA Initiative (Prop. 63) that acknowledged the following:

The Mental Health Services Act acknowledged the following:

- *With effective treatment and support, recovery from mental illness is feasible for most people...*
- *Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers...*

Now the work begins. How do we utilize our strengths, gifts, commitment and knowledge to fulfill the potential that the Mental Health Services Act offers us?



III. Focus on Systems

If we are serious about the vision of recovery, then the mental health system of the last century—which for the most part was a system characterized by low expectations, control and no consumer-based vision—must disappear.

Bill Anthony



The challenge of moving a “system of care” from one set of assumptions and program practices to a new approach to the provision of services cannot be underestimated. For example, the discussion about “transformation” must be applied to all levels of the current treatment system – from hospitalization and other institutional care to drop-in centers, “warm lines” and supportive housing. The realization of a recovery vision in a public mental health system is as much about where we provide services as it is about what we do. A possible frailty of the MHSA process thus far is that it spends most of its time on the less controversial aspects of implementing a recovery approach on the less costly parts of the service system while ignoring the need to challenge the use of inpatient and other institutional settings.

The other major challenge facing our efforts is the seeming incompatibility between a recovery-oriented system focused on enhancing the quality of life of persons living with psychiatric disability and the deficit/disease orientation of the Medicaid and Medicare insurance programs. Under the leadership of the CA Institute for Mental Health and with the support and participation of all the major stakeholders, we are working to clarify and enhance the relationship between MediCal and recovery-oriented practice. Approaching service delivery from a ‘recovery-orientation’ while documenting service provision based on narrow medical necessity criteria requires a different kind of multi-lingual capacity.

A. Incorporating a Recovery Perspective into System of Care Development

Most counties have committees whose responsibility includes development of their Adult System of Care (ASOC). Over the past year, these committees may have considered how (or whether) wellness and recovery approaches might be incorporated into service delivery and ASOC development. In some counties, the ASOC Committee has dedicated a subcommittee to consider recovery approaches. Other counties have established a separate Recovery Task Force, or have incorporated the discussion into the agenda of the county mental health department’s Executive Management Team. What is

important is to create an ongoing vehicle for the discussion that includes participation of all stakeholders.

Wellness and Recovery Task Force The CA Wellness/Recovery Task Force recommends that the topic of how to incorporate wellness and recovery into adult systems of care be assigned to a subcommittee, work group or task force of the mental health department.

The chair of the committee hosting this planning effort needs direct access to the county mental health director. In addition, a wellness and recovery planning effort needs to have input from a variety of constituents of the County's ASOC. The composition of this group should include consumers, family advocates, community-based organizations, adult system of care line and supervisory staff, inpatient staff, and psychiatric emergency services staff. The group should also include representatives from housing, employment and education services. Those who chose to be part of the task force need to be committed to work on an on-going basis over the long haul.

The Wellness and Recovery planning effort would be engaged in the following tasks:

- Explore what a system looks like that supports wellness and recovery by looking at other systems and reviewing the literature. Conduct focus groups with a variety of consumer cohorts (transition age youth, ethnic/cultural minorities, older adults) to gather information about their perspective on the concepts and implementation issues of wellness and recovery approaches
- Assessing the readiness of the adult system of care to begin implementation
- Develop and conduct an educational campaign for all stakeholders
- Develop a plan to effect system and practice to support people in recovery.
- Work with administration to identify and advocate for the necessary systemic changes.
- Develop sub-committees to address cultural competence, client and family inclusion within the system of care, spirituality, and education of staff
- Monitoring of the implementation plan throughout the system

B. Characteristics of a Recovery-Oriented System

Now that the MHSA has provided us the opportunity to transform the mental health system, let us focus on the systemic best practices. The challenge is to create a system that incorporates the philosophy and values of cultural competence and recovery-oriented practice. The CA Wellness Recovery Task Force outlined the following cornerstones of a recovery-oriented system:

- A widespread understanding of, and belief in, recovery among staff, consumers and family members
- Quality of life program elements that lead to the creation of integrated services
- Quality of life outcome data incorporated into program design monitoring
- Consumers and family members widely employed throughout mental health administration and programs in a variety of roles.
- Leadership promotion of recovery-oriented principles and practices
- Staff training focused on recovery-oriented values, principles and practices
- Partner with community resources to maximize access
- Reduction in the use of hospitals and institutional settings (if not the elimination)
- People who are homeless, institutionalized, and those in transition from the children's system of care to adulthood are effectively engaged and supported
- Consumers and families involved in all aspects of system planning and management

While many programs are making substantial efforts in these areas, transformations of social systems are very difficult to achieve. The following collection of ideas, models, and resources is presented as a guide for the challenging task ahead:

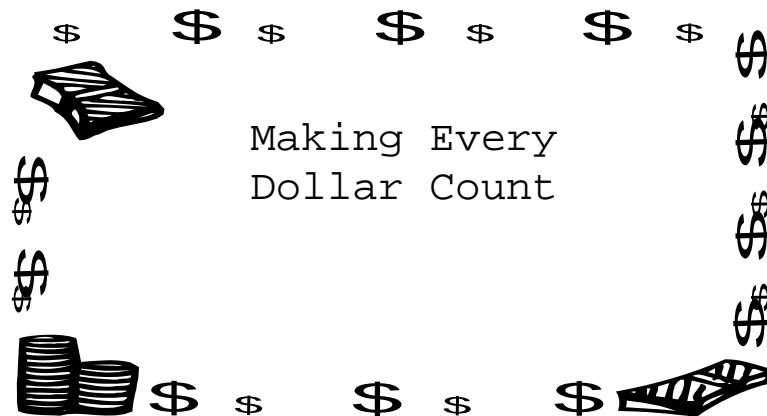
Be Strategic About the Use of Funds. System transformation cannot be

accomplished without the redirection of local resources from hospital and other institutional care settings.

A major potential for use of MHSA funding is to develop alternatives at the acute and institutional end of the service spectrum in order to redirect the resources now spent on high cost hospital-based treatment and skilled nursing facilities into an expansion of community resources.

While the MHSA represents a significant new funding source for mental health systems, it is still a relatively small percentage of the overall budget for local mental health services. Therefore, the most effective way to utilize MHSA funds as a transformative influence is to develop local alternatives to institutional treatment that will allow for fewer acute inpatient stays, less state hospital and IMD utilization, and less jail incarceration. This, in turn, allows local mental health systems to use funds that would otherwise be targeted for institutional placement for the development of community-based alternatives and a broad array of supportive housing and vocational services.

In other words, MHSA funds must be used strategically to leverage local dollars and state resources currently being used in high cost settings or in non-Medi-Cal reimbursable institutions (IMDs and free-standing psychiatric facilities) by developing residential treatment programs explicitly designed to provide an alternative to its institutional counterpart. This approach can turn each dollar of MHSA funding into two or three dollars of available local resources.



Characteristics of a recovery oriented system

Dr. William Anthony of Boston University initially articulated the characteristics of a recovery-oriented system in a fall 2000 article for the Psychiatric Rehabilitation Journal. The CA Wellness Recovery Task Force adapted these principles into the chart that follows.

<i>System Dimension</i>	<i>System Standard</i>
Design	<p><i>Mission includes a recovery vision as driving the system and challenges the presumption of life-long need for mental health services</i></p> <p><i>Mission implies recovery measures as an overall outcome for system (e.g., self-determination, role functioning)</i></p> <p><i>Services are designed to meet the need of ethnic and cultural groups.</i></p> <p><i>Services are designed to enhance the community's capacity to support community members experiencing mental health issues.</i></p> <p><i>Core set of services are identified based on consumer's needs and choices</i></p> <p><i>Services are designed to facilitate each individual's integration into the community of their choice</i></p> <p><i>Services are designed to be integrated and address co-occurring disorders</i></p>
Evaluation	<p><i>Incorporate 'quality of life' outcome and cost data into program monitoring and accountability</i></p> <p><i>Consumer and family measures of satisfaction and dissatisfaction are included in system evaluation</i></p>
Leadership	<p><i>Leadership constantly reinforces recovery vision and recovery system standards</i></p> <p><i>Leadership has created a structure (e.g., Wellness/ Recovery Task force) where consumers, family members and providers come together to develop strategies to implement wellness and recovery-oriented practices</i></p> <p><i>Leadership nurtures, encourages staff to play and explore, brings their lives into the work, and cherishes staff for their</i></p>

<i>System Dimension</i>	<i>System Standard</i>
<i>Leadership</i> (cont'd)	<p><i>individual gifts and caring</i></p> <p><i>Leadership has created opportunities for direct consumer and family participation in management (e.g., Office of Consumer Empowerment, Office of Consumer Affairs, Consumer Liaison Advocate)</i></p>
<i>Management</i>	<p><i>Recovery-values are reflected in supervisory relationships</i></p> <p><i>Decision-making is decentralized giving staff real authority in programs (e.g., access to funds to meet consumer needs)</i></p> <p><i>Policies governing risk management encourage risk-taking and view failures as opportunities for learning except in those instances where harm is imminent</i></p> <p><i>Policies insure that the MIS system collects information on service process and outcomes</i></p> <p><i>Policies encourage service programs to be recovery-oriented (i.e., procedures are compatible with recovery values and consumer outcomes)</i></p> <p><i>Policies encourage the assignment of service staff to be based on competencies and preferences rather than education and credentials</i></p>
<i>Service Integration</i>	<p><i>Coordination of services is provided for each consumer who wants and needs it</i></p> <p><i>Policies encourage the development and implementation of collaborative strategies to achieve consumer outcomes that cross service systems</i></p> <p><i>Policies do not allow for discrimination against persons with co-occurring disorders</i></p>
<i>Comprehensiveness</i>	<p><i>Consumers' goals address functioning in living, learning, working, and/or social environments</i></p> <p><i>Consumers' goals address the development of support systems</i></p> <p><i>Consumers' goals address building on services and supports available within the broader community</i></p>

<i>System Dimension</i>	<i>System Standard</i>
Consumer and Family Involvement	<p><i>Individuals with psychiatric disabilities and families are actively sought for employment at all levels in organization</i></p> <p><i>User-controlled, self-help services are available in all geographic areas</i></p> <p><i>Family education programs and support groups are available for family members</i></p> <p><i>Consumers and families are integrally involved in system design and evaluation</i></p> <p><i>A leadership development program is available to support meaningful participation in governance and system decision-making processes</i></p> <p><i>Services have a clearly defined procedure for eliciting and responding to client and family suggestions and/or complaints</i></p>
Cultural Relevance	<p><i>Policies insure that assessments, planning, and services' interventions are provided in a culturally competent manner</i></p> <p><i>Policies insure that the knowledge, skills and attitudes of personnel enable them to provide effective care for the culturally- diverse populations that might wish to use the system</i></p> <p><i>Policies emphasize deriving services, programs and interventions from the community(ies) being served</i></p>
Advocacy	<p><i>Staff and leadership advocate for a holistic understanding of people served appreciating the interplay of the mind/body connection.</i></p> <p><i>Staff and leadership advocate for an understanding of the potential for growth and recovery of people served</i></p> <p><i>Staff and leadership advocate for the recognition of the civil rights of people served</i></p> <p><i>Staff and leadership advocate for the implementation of the Supreme Court's Olmstead decision</i></p> <p><i>Staff and leadership advocate for the use of tools that emphasize personal authority (e.g., the development and implementation of psychiatric advance directives)</i></p>

<i>System Dimension</i>	<i>System Standard</i>
Training	<p><i>Policies insure that all levels of staff understand the principles of recovery-oriented systems and the psychosocial rehabilitation approach to services and practice</i></p> <p><i>Policies encourage selection and training methods designed to improve knowledge, attitudes, and skills necessary to provide rehabilitation and recovery-oriented services</i></p> <p><i>Supervision addresses the implementation of new knowledge into practice</i></p> <p><i>Policies insure that staff training includes training provided by consumers and family members</i></p> <p><i>Policies insure that all levels of staff are competent in integrated dual diagnosis treatment approaches</i></p>
Funding	<p><i>Funding priorities emphasize developing alternatives to hospital and institutional care to transform reliance on medical/institutionally based care to a community-based, rehabilitation capacity</i></p> <p><i>Funding priorities emphasize redirecting local dollars saved by minimizing use of hospitals and Institutes for Mental</i></p>
Access	<p><i>Services are available at locations that allow for access to community resources and public transportation</i></p> <p><i>Services are provided in settings that are wheelchair accessible</i></p> <p><i>Access to services and social supports is not contingent on medication compliance</i></p> <p><i>Timely access to services is ongoing and consistent with the principle of early intervention and in order to fore-stall relapses</i></p> <p><i>Meetings of governance and other decision-making bodies are accessible (e.g., public transportation, cab vouchers, elevators)</i></p>

C. A Guide for Recovery-Oriented Leaders

It is important as we attempt to transform our mental health system to a recovery-based system that we actually transform our culture instead of just changing the sign on the door while doing the same old things inside. To be able to tell the difference, we must be able to identify clearly the core elements of a recovery culture when we see them. The MHA Village Integrated Services Agency has made several efforts in this regard. This paper attempts to define key elements of each of the four broad elements of recovery culture we have identified for recovery-oriented leaders: *Hope, Authority, Healing, and Community Integration*.

Hope. Hope is clearly the first step in anyone's recovery and our culture must actively promote it.

Hope thrives in a delicate balance between safety and risk; too far one way or the other and the organization will lose its way. Hopeful leaders' foster hopeful staffs that then go out and encourage hope in the people they are serving.¹¹

- Stories and celebrations of hope should be spread by both staff and consumers
- Hiring of people who are open about their psychiatric disability fills the program with living examples of hope
- Goal setting for both consumers and staff should focus on growth rather than stability or risk avoidance, building on strengths as well as overcoming obstacles

Authority. The distribution of authority has widespread implications for promoting empowerment, self-responsibility, risk-taking, and learning from mistakes for both staff and consumers.

- Decentralized decision-making gives line staff real authority in the program (e.g. giving staff money for them to be responsible for and choosing how to spend)

¹¹ See Recovery Oriented Leadership: a beginning dialogue ... available from Community Activators, (206) 463-3666 www.communityactivators.com

- The program should include a substantive consumer voice at every level of the program's decision-making process
- "Consumer driven" needs to be an overt, highly discussed part of the culture to ensure that decisions flow, as much as possible, up from the needs of the people we're helping rather than down from administrative authorities
- Planned risk-taking, not care-taking or reckless abandonment, needs to be actively encouraged for both consumers and staff if growth is going to occur
- Boundaries between staff and consumers need to be as low as possible to decrease "us vs. them" stigma
- Staff and consumers helping each other without "that's not my job" or "that's your job" defensiveness is a concrete, powerful step
- Staff and consumers need to have multiple roles and multiple kinds of relationships with each other for consumers to move beyond illness roles in their recovery
- Staff and consumers both should feel important, valued, even treasured by those who have 'positional authority' over them
- Acknowledging that everyone is an expert in some way, a "chief" of something, with 'personal authority'

Healing. In a recovery program, the focus is on healing and growth for the person rather than symptom relief for the illness.

To acknowledge the parts of us that need healing, and receive compassion and encouragement as we work towards finding wholeness and health.¹²

- The first priorities are engagement, welcoming, and relationship building because the foundation of a good recovery process is a good relationship, not a good diagnosis

¹² See Recovery Oriented Leadership

- A “counterculture of acceptance” needs to be established within the program to create an emotionally safe place for these traditionally “unacceptable”, rejected people to recover within
- The usage of respectful language rather than prejudicial, clinical language needs to be so pervasive that people can read their own charts or overhear staff discussing them and feel accepted and understood
- A healing environment is an emotionally rich environment filled with open displays of caring and connection
- To be effective, staff must be in touch with why their hearts brought them into this work and be energized by practicing their gifts

Community Integration. To achieve meaningful roles in life we cannot stay isolated away from the world.

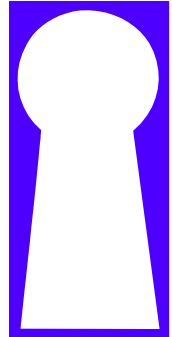
- Both staff and consumers must be mobile and actually work together out in the community on “real life” issues
- The program must demonstrate accountability to the community by collecting “socially responsible”, quality-of-life outcomes like housing, decrease in jailing, employment, and finances
- The program needs to focus on community coalition building and “giving back” to the community if the program and the people it works with are going to be accepted
- Staff and consumers need to be actively involved in the difficult work of fighting stigma if our world is going to become a better place for people with psychiatric disabilities

It has become increasingly clear to us that leaders need to treat staff the way they want staff to treat consumers. Only staff members that have hope, personal power, responsibility and meaningful roles can help consumers have hope, personal power, responsibility and meaningful roles.

D. Creating “Exits” from the Mental Health System

People with mental health issues can and do recover. In a system that has taken a long time to embrace the concept of recovery for people with these issues, it is probably not surprising that the idea of exiting the system poses challenges as well as opportunities. These opportunities and challenges require us to re-examine the current mental health structure and practice.

Barriers. In discussing exits, issues arise on a number of levels: system, provider, consumer and societal. The re-orientation of a system to include recovery and exiting as a concept at the outset of treatment has manifestations throughout the system. Some of the barriers that must be addressed by the mental health system include:



Lack of access to appropriate services. The current system requires that a person utilize acute services multiple times before rehabilitation and recovery services are offered. Once in the rehabilitation system, there is a presumption of “life-long” involvement with no exit planning. Conversely, in some programs, when an individual begins to get better, services may be withdrawn without adequate attention paid to linkage with or development of natural support systems.

Re-accessing services. If someone does leave the system, re-accessing services usually comes about by entering at the highest level of care or being put on a significant waiting list or participating in a lengthy intake process.

Insurance barriers. There is a shortage of providers willing to accept Medi-Cal or Medicare in the private sector not to mention restrictive Medi-Cal practices in some counties.

Subsidized housing barriers. Affordable housing is extremely limited. Frequently, for persons to have subsidized housing there is a requirement to receive case management services.

Conflicting imperatives – billing vs. recovery-oriented services. The language of compliance is medical-model and disease focused, and this is the requirement for reimbursement of services. When a person has exited the system and s/he needs a brief interaction for problem solving or support, they may not meet the criteria for “medical necessity,” and therefore, not be eligible for reimbursable services.

SSI/SSDI barriers. The work incentives available through SSI and SSDI are confusing and difficult to understand. In addition, communication from the Social Security Administration (SSA) invokes fear more than anything else. The

result is that consumers do not want to jeopardize their benefits and providers do not encourage them to do so.

Strategies. There are strategies that have been developed to overcome these barriers.

Exit planning at the onset of treatment. When the initial rehabilitation and recovery plan is written, services can be explained as time-limited. Rather than the message that the consumer's relationship to the mental health system of care is forever, the message can be that services are designed to facilitate each individual's movement back into their community of choice. The job of the provider is to assist with the development of skills and resources needed to return to the community.

Flexible service delivery. Utilizing mental health services on an as-needed basis needs to be normalized. Needing a case manager for a period of time does not mean that the individual will always require that level of service. The system needs to include an easy point of entry for focused, specific and time-limited services.



Identify core skills for successful exits. The work of the mental health system needs to focus on the core competencies required for success in the community. Skills like self-advocacy, developing and using a self-assessment tool such as the Wellness Recovery Action Plan (WRAP), or building social and community connections for support are basics that consumers need to develop to move beyond the system of care.

Increased funding for self-help programs. Peer-provided services offer a unique safety net option as well as opportunities to relate to others that have succeeded and built meaningful lives.

Redirect funds from hospital and institutional-based services. In order to expand and develop necessary community supports it will be necessary to redirect funds into community-based services.

Increased housing options. Affordable housing is essential to successfully exiting from the mental health system.

Action Steps. Here are some ideas for first steps to overcoming barriers preventing or discouraging consumers from exiting the system.

Increase number of community physicians willing to provide medication. Create list of psychiatrists who accept Medi-Cal and/or Medicare. Brainstorm ways to increase the number of psychiatrists who will accept Medi-cal and

Medicare. It is crucial to provide consultation services to primary care physicians who are prescribing psychiatric medications.

Provide training for providers. Provide training tools for staff that promote and demonstrate a strengths-based approach including an emphasis on skill development and fostering natural supports.

Increase the number of consumer providers. Hiring more consumers as part of rehabilitation and treatment teams creates more examples that recovery is possible.

Create a task force to explore and address barriers to employment. Fear of losing benefits is the number one reason individuals cite for not going back to work. Develop a task force that includes members from the Mental Health Directors Association and the Department of Rehabilitation address communication issues, training issues, and use of work incentives to make inroads into this long-standing barrier.

Include exit strategies as part of program descriptions. All programs should include a statement in their description of services that would give ways that programs assist individuals in moving on with their lives. For example, "To assist consumers in moving on with their lives, this program provides: 1) training in the skills needed to live independently; 2) coordination with vocational services; 3) assistance in finding housing; 4) peer support; and 5) intermittent support and problem-solving for persons who have graduated from the program."

Create an "Office of Housing." The sole function of this entity would be to make recommendations for ways to create more affordable housing.



Examples.

Mental Health Association of Los Angeles, Project Return, The Next Step

Project Return Wellness Centers (located in Long Beach and South Los Angeles) blend physical and mental health care strategies to help individuals achieve and maintain healthy lifestyles. The centers offer awareness classes on living with chronic health conditions, sponsor support groups to help individuals build a peer network, provide goal-oriented counseling and train individuals to become peer counselors. (<http://www.mhala.org>)

Stanislaus County Behavioral Health and Recovery Services, Wellness

Recovery Center. The Wellness Recovery Center is a “partnership” of a peer recovery network, a medication clinic, and housing and employment services. The Center provides medication services, including consultation with the primary care physician, an identified staff person to continue to assist clients (on an as-needed basis), and peer support.

E. The Role of Religion and Spirituality in Recovery

Religion and spirituality are often associated with recovery from both substance abuse problems and/or psychiatric disabilities perspective. Sullivan (1993) found 48% of respondents indicated that spirituality, which was defined broadly, was important in their recovery process. Consumer/survivors listed the following as some of the reasons for their commitment to religion and spirituality: strength for coping, social support, a sense of coherence, and the feeling of being a "whole person." In Lindgren and Coursey's (1995) study 74% of the participants said that religion or spirituality helped when they were ill.

Although many agree that religion and spirituality can be an important part of the recovery process, there is less agreement about the role it should play in therapy/treatment. Falot (1998) points to the need for greater consideration of spirituality in programming for individuals with a serious mental illness. Bussema & Bussema (2000) found that participants' faith stories lacked the emotional and social support typically gained from religious communities. Instead, most individuals reported they depend primarily on their peer support networks within the rehabilitation system. This raises concerns because both the religious community and mental health service providers often overlook religious and spiritual needs of individuals with psychiatric disabilities.

We believe that mental health providers should consider the following questions:

- How can we address the religious or spiritual needs of consumers in treatment?
- What religious institutions exist in the community that could be a resource for our consumers?
- Are these religious institutions aware of the services we offer?
- Are the local clergy knowledgeable about the needs and interests of people with psychiatric disabilities? If not, how can we address this need?

Resources

The following are some websites that address the issues of mental health and religion:

Faith in Recovery

<http://www.faithinrecovery.com>

Holistic Online, Anxiety: Prayer/Spirituality

http://www.holistic-online.com/Remedies/Anxiety/anx_prayer.htm

Jewish Association for the Mentally Ill, UK (JAMI)

<http://www.jamiuk.org>

Mental Health Ministries

<http://www.mentalhealthministries.net>

National Catholic Partnership on Disability (NCPD)

<http://www.ncpd.org>

National Organization on Disability, Religion and Disability Program

<http://www.nod.org/index.cfm?fuseaction=Page.viewPage&pageId=9>

Pathways to Promise: Ministry and Mental Illness

<http://www.pathways2promise.org/index.htm>



F. Consumers in the Mental Health Workforce

No single experience is a stronger stigma reducer, “us versus them” barrier breaker, or humanizer than working alongside consumers and family members. No single experience is more likely to change the entire mental health culture.

Mark Ragins, M.D.



Over the last 10 years, mental health providers have increasingly recognized the value of including persons with psychiatric disabilities in the mental health workforce. Hiring consumers reflects the most basic values of psychosocial rehabilitation; community integration, belief in recovery, self-sufficiency and contributes to the creation of a multicultural workforce.

Consumers in the workforce benefit the organization in a number of ways. Non-consumer staff has the opportunity to see “recovery in action.” They become more hopeful and often demonstrate increased empathy with their clients. Clients have the experience of being with a person in recovery. The mere presence of consumer staff breaks down stigma, provides role models, demonstrates that recovery is possible, and that there is reason for hope.

Consumers move into the mental health workforce primarily in three ways: 1) by working in consumer-run organizations such as Mental Health Consumer Concerns in Contra Costa County; 2) peer counseling positions or positions identified specifically for consumers; and 3) regular employee positions such as service coordinator, patient rights advocate, rehabilitation counselor, or job coach.

Developing Jobs for Consumers. Hiring consumers can be viewed as a crucial step in developing a diverse, culturally competent, rehabilitation and recovery-oriented workforce. This will involve the following activities:

Reviewing workforce needs to evaluate service needs and organizational gaps. All areas of employment should be reviewed including administrative positions and direct service positions.

Reviewing job descriptions. Job descriptions should add experience as a consumer of mental health services as part of the job qualifications. Agencies should create educational equivalencies to standard college requirements including successful completion of peer counseling certificates or requiring CPRP certifications for specific positions. Stigmatizing language must also be removed from all job descriptions.

Creating diverse teams. Teams of multi-discipline staff should integrate peer positions and create flexible schedules and job sharing opportunities.

Developing career ladders. Entry-level peer counseling positions should include opportunities for advancement thus creating a culture where all positions could potentially be held by consumers. Agencies should provide support, and when possible opportunities for continuing education. Performance reviews should be used to identify areas for professional growth and job qualifications should be matched to job duties.

Preparing the Work Environment. Organizations that hire consumers have found that it is necessary to involve existing staff in discussions of this initiative. It provides them an opportunity to express their concerns. It is also necessary to be aware of the issues that the consumer staff may have as they begin to work.

Concerns of Staff

- Questions about dual relationships and boundaries
- Reasonable accommodations will be “unreasonable”
- The status of their profession will be diminished
- Consumer staff will require an unreasonable amount of support and lack necessary skills
- Questions about the role of consumer and non-consumer staff in staff meetings and social events

Concerns of Consumer Employees

- Impact of employment on benefits
- Fears about ability to do the job
- Fear of not being liked or accepted
- Potential loss of friendships with other consumers

Creating a Consumer-staff Friendly Work Environment. Addressing the concerns of staff (and perhaps the concerns of the Board of Directors, unions, and civil service) and creating an organization with a true recovery

vision will require an ongoing commitment from all levels of the organization. Issues to be addressed include:

Role confusion. Hiring consumers requires a shift from client to colleague with both-consumer and non-consumer staff making a conscious effort to acknowledge the change.

Inclusion. Inclusion in both professional and social staff activities is important as consumer employees must be treated with the same regard and respect as any employee. Consumer staff should be included in all trainings as well as having a specialized track to address their specific needs.

Supervision. The supervisor must be supportive, communicate clearly and directly and be able to define job duties clearly, as with any staff. Standard job expectations must be maintained. The supervisor must recognize and be able to provide additional support and training. *Work supervisor should not be the employee's service provider.*

Support. An organization must be prepared to discuss and provide reasonable accommodations, develop support groups for consumer employees and provide ongoing training.

Education and Training for Consumers. There are a number of educational programs available to prepare consumers for employment in mental health. These include both mental health program-sponsored training (for example peer counseling programs) and degree and certificate programs in the educational community. In either case, the curriculum should include communication skills, interpersonal skills, ethics including boundaries and roles, confidentiality, work skills, and an overview of resources.

Peer Counselor Training. Programs can be offered through the agency or in partnership with a community college. Curriculums are available as are experienced peer instructors. Existing programs range in length from 10 to 16 weeks.

Human Services Certificate Programs. A number of community colleges in California offer a certificate program in human services. Some programs may include coursework on psychosocial rehabilitation. Classes are integrated with students from a wide variety of backgrounds.

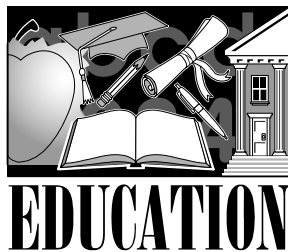
Curriculum in Psychosocial Rehabilitation. CASRA has developed a 5-course curriculum in recovery-oriented, psychosocial rehabilitation practice. Coursework includes Introduction to Psychosocial Rehabilitation, The Helping Relationship, Rehabilitation and Recovery, Community Integration and a

Fieldwork Seminar. The curriculum can be offered through a local community college or as in-service training for new or potential staff.

Certification as a Psychiatric Rehabilitation Practitioner. The United States Psychiatric Rehabilitation Association (USPRA) offers a test-based credential that validates the knowledge, skill, and ability to provide social rehabilitation services. To qualify for the exam, individuals must have a combination of education, experience and training in social rehabilitation. The CPRP is a professional standard that is within the reach of consumer staff.

When we only look for formal degrees in potential employees, we miss the experiential knowledge, the amazing level of wisdom that consumer employees bring to the organization. Consumers have a level of distrust around MH services, particularly when they have received involuntary services. Hiring consumers results in increased trust between consumers and staff.

Sheila Boltz~ Sacramento, CA



Resources

Solomon, M., Jonikas, J., Cook, J., and Kerouac, J. Positive Partnerships: How Consumers and Nonconsumers Can Work Together as Service Providers. National Research and Training Center on Psychiatric Disability. The manual is available from CASRA.

California Association of Social Rehabilitation Agencies. (2006). Hiring Consumers: Guide for Readiness Assessment and Planning. This planning tool is available from CASRA.

G. Outcomes

To show that we are not just treating the symptoms of mental illness, but improving the lives of people living with mental illness, we must evaluate the effectiveness of our activities in addressing quality of life outcomes.

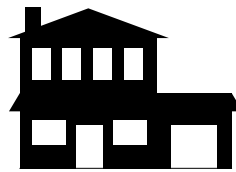
The AB 2034 programs'¹³ have collected quality of life outcomes from their inception. Their ability to document effectiveness, especially in decreased homelessness, incarceration, hospitalization and increased employment, has been instrumental to the political support for the Mental Health Services Act (Nov. 2004).

Impartial quality of life measures are objective indicators of consumer status in the areas of housing, employment, education, decrease in criminal activity, income, control over one's own life (conservator/payee), social support, and physical health.

Ideally, the outcome system does "real-time" tracking of consumer status in a number of different domains.

Objective Quality of Life (Real-time) Domains:

- Housing
- Employment
- Conservatorship
- Payeeship
- Incarceration
- Hospitalization
- Criminal Victimization



¹³ The California Legislature passed Assembly Bill 2034 (AB 2034) in 2000 to fund programs that provide outreach and engagement services to persons with mental illness who are homeless or at risk of homelessness. By offering a comprehensive array of voluntary services that include accessible and affordable housing, clients are empowered to fully integrate into the community and reduce their homelessness, incarceration, and hospitalization rates.

Services are client directed and may include; supportive housing, assessment, eligibility determination for other services, service plan development, service coordination, advocacy, coordination and access to medications, peer and self-help, pre-vocational and employment services.

Although not an all-inclusive list of possible outcomes, these domains reflect areas that most people would agree form the core of an individual's quality of life. More importantly, they reflect very closely what members and family members have stated are the areas that they want the mental health system to help them achieve.

**JOY
DELIGHT
LOVE
LAUGHTER
HEALTH
WEALTH
PEACE
HARMONY
SUCCESS
CONTENTMENT**

H. Consumer Satisfaction

Factors outside of the influence of client and provider may often provide barriers to achieving goals. That is why it is critical to gather information from service recipients regarding their satisfaction with the provision of services.

In addition to requesting satisfaction/dissatisfaction information from those who receive services, we should also make multiple efforts to hear the stories of those who vote with their feet. It is critical that we understand the depth and breadth of dissatisfaction with services, their accessibility, relevance and effectiveness.



The *Consumer Report Card* developed under the auspices of the Mental Health Statistics Improvement Program (MHSIP) continues to represent the standard in the field. The *Report Card* was developed in collaboration between consumers, the MHSIP community and the Center for Mental Health Services.

This focus on consumer needs goes beyond the inclusion of consumers in developing and evaluating the Report Card's indicators and measures. Indeed, the domains, concerns, indicators, and measures of the MHSIP report card are specifically designed to assess consumer concerns with various aspects of mental health treatment, not merely global satisfaction with mental health services. The report card's indicators include both objective measures of a provider's commitment to mental healthcare (e.g., the average resources expended on mental health services), and consumer assessment of the convenience, appropriateness, and outcomes of the services the system supports.

The MHSIP report card is unique among similar documents in measuring those dimensions that matter most to mental health consumers:

It is **consumer-oriented** - The report card was developed with consumers and family members and reflects their concerns.

It is **value-based** - The MHSIP report card explicitly addresses issues of consumer choice, empowerment, and involvement. Though concepts and measures of recovery, personhood, and self-management are evolving, the report card includes these as integral elements. In addition, the report card's concerns, indicators, and measures reflect expectations that appropriate services will be available, easily accessible, developed with and by consumers, and offered in the least restrictive setting.

It emphasizes ***concerns*** related to ***serious mental illness*** - There is a clear emphasis on issues related to serious mental illnesses and serious emotional disturbances in the report card's indicators and measures. However, the document also is intended to address mental healthcare delivery to all people with mental health needs, both children and adults.

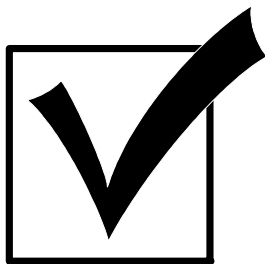
It includes ***outcomes*** - As noted, many report cards avoid outcomes. While there may be additional burden or costs associated with obtaining such data, this is the critical element in determining the performance of a provider or system.

It is ***research-based*** - The development of the report card included an extensive review of the literature on performance measures, outcomes, and report cards. Expert consultants were involved in this effort.

It is ***cost and burden conscious*** - The Task Force went to considerable effort to minimize the cost and burden of obtaining the needed data.

MHSIP Consumer Report Card – Sample Items

Consumers are asked to rate their experiences on a 5-point scale from “Strongly Agree” to “Strongly Disagree” in four domains including:



General Satisfaction:

Access:

Quality/Appropriateness:

Outcomes:

I. Operationalizing and Measuring Recovery – The Milestones of Recovery Scale (MORS)

The concept of recovery has become nearly universal in public mental health policy discussions. However, it remains difficult to define and even more difficult to measure. Much of this is because many qualities of recovery are reflective of the deeply personal, internal experience of the person.

When it comes to demonstrating our effectiveness to the public and funding sources, it is much easier demonstrate meaningful changes in the objective circumstances of the lives of consumers we serve (e.g., more jobs, fewer hospitalizations and incarcerations, less homelessness) than in their internal subjective states.

Dave Pilon and his colleagues at the Village Integrated Services Agency (a program of the National Mental Health Association of Greater Los Angeles) have developed a scale that describes what they believe are the most important objective and measurable correlates of the process referred to as “recovery.” This approach began in the spring of 1997 under the aegis of the California Association of Social Rehabilitation Agencies (CASRA).

The reliability and validity studies of the MORS have been very positive. The MORS is also strongly correlated in the predicted direction with several other instruments (LOCUS and MCAS) and they have found that the consumer’s milestone of recovery is highly correlated in the expected direction with their objective quality of life indicators such as residential and employment statuses as well as hospital and jail tenure.

It should be noted that the scale is designed as an *administrative* tool rather than a clinical tool. It can be used to evaluate program/system effectiveness and, most importantly, assignment to a level of care (Case Rating or caseload size design).

Resources

<p>Pilon, D, Ph.D. & Ragins, M, M.D., Milestones of Recovery Scale (MORS) www.village-isa.org</p>
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J. Evidence-Based Programs

The two most common strategies promoted to address the needs of adults with psychiatric disabilities are to redesign services based upon recovery principles and to increase the availability of services with strong research support. The latter movement has been developed under the rubric of “evidence-based practices.”

Evidence-based practice (EBP) is defined by the Institute of Medicine as – the integration of best-researched evidence and clinical expertise with patient values.”

According to the Institute of Medicine report, *Crossing the Quality Chasm*, “*in a transformed mental health system, consistent use of evidence-based, state-of-the-art medication and psychotherapies will be standard practice throughout the mental health system.*

Knowledge about evidence-based practices (the range of treatments and services of well-documented effectiveness), as well as emerging best practices (treatments and services with a promising but less thoroughly documented evidentiary base), will be widely circulated and used in a variety of settings.”¹⁴

The California Institute for Mental Health has developed an initiative to disseminate and adopt science-based practices, and build consensus for a shared vision of evidence-based practice in California. The CIMH initiative maintains that evidence-based practices are relevant only when various levels of scientific evidence and stakeholder values come together. This approach attempts to reconcile the potential conflicts between a scientific, objective, evidence-based approach and the importance of the subjective experience and autonomous rights of persons who are in recovery. It also acknowledges that there are other practices (often referred to as “promising practices”) which have not yet been studied, or which have been examined using qualitative methodologies.

SAMHSA Toolkits. The Substance Abuse and Mental Health Services Administration (SAMHSA) through its Center for Mental Health Services (CMHS) has introduced several Evidence-based Practice Implementation Resource Kits. Five of them are:

Illness Management and Recovery emphasizes helping people to set personal goals and to implement action strategies in their everyday lives.

¹⁴ Institute of Medicine (2001). *Crossing the Quality Chasm*. Washington, D.C.:Author

Information on building social support, coping with problems and symptoms, using medication effectively and gets needs met in the mental health system are addressed.

Assertive Community Treatment offers services that are customized to the individual needs of the consumer, delivered by a team of practitioners, and available 24 hours a day. Housing, finances, employment, medical care, family life and symptom management are addressed.

Family Psychoeducation involves a partnership among consumers, families and supportive practitioners. Through relationship building, education, collaboration, problem solving, and atmosphere of hope and cooperation, family psycho-education helps consumers and their supporters.

Supported Employment is a well-defined approach to helping people with mental illnesses achieve and maintain competitive employment.

Co-occurring Disorders: Integrated Dual Diagnosis Treatment is for people who have co-occurring disorders, mental illness and a substance abuse addiction. This treatment approach helps people recover by providing the mental health and substance abuse services at the same time and in one setting.

Resources

Anthony, W. A. (2005). Value based practices. *Psychiatric Rehabilitation Journal* 29(3), 1.

Farkas, M., Gagne, C. Anthony, W. & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal*, 41(2) 145-153.

National Mental Health Information Center. *Evidence-Based Practices: Shaping Mental Health Services Toward Recovery*. The SAMHSA Toolkits can be ordered or downloaded at www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits

California Institute for Mental Health. *Values-Driven Evidence-Based Practices* www.cimh.org/research/adult_values.cfm

L. Partnerships and Collaboration

As the mental health system moves from viewing the consumer as a set of symptoms to a whole person with multiple strengths and desires, the need to partner and collaborate with other entities becomes crucial to service delivery. Mental health services in isolation do not work. Consumers need access to housing, employment, medical care, and education. There are many examples where mental health organizations have successfully collaborated with other departments and providers to improve the quality of life for persons with serious mental illness. These, as well as relevant resource information are presented in the following pages.



*Working
Together
to Let
Recovery
Work*

Collaboration with local housing authorities.

Everyone needs a place to live – a place to call home. Unfortunately, millions of people with disabilities today stand little chance of having a decent and affordable home of their own. This is particularly true for adults with disabilities who receive federal Supplemental Security Income (SSI) benefits.

Housing affordability and the need for housing assistance is measured primarily by the percentage of income that a household must pay each month for housing costs. Under current federal guidelines, housing is considered affordable when the cost of monthly rent plus utilities does not exceed 30 % of monthly household income. In California, it is estimated that a person with a disability needs to spend over 99% of his/her income to rent a modest one-bedroom housing unit. It is crucial that mental health providers develop and maintain both a positive and collaborative working relationship with the local housing authority.

The following are some of the programs offered by local Housing Authorities that can benefit individuals diagnosed with mental illness. Not all programs are available in all areas.

Housing Choice Voucher Program is a program of the Federal Housing and Urban Development (HUD) Section 8 rental assistance program. Administered by local housing authorities, eligible individuals receive a voucher that covers a portion of their rent with the tenant expected to pay the balance. The tenant's share is an affordable percentage of their income and is generally calculated to at 30 to 40 percent of their monthly-adjusted gross income for rent and utilities.

The Section 8 Moderate Rehabilitation Program (Mod Rehab or Section 811) is a unit-based rental subsidy program for low and moderate-income

individuals and families. While the Housing Authority administers the program, HUD provides rent subsidy payments to private and nonprofit property owners for rental units rehabilitated under this program. Mod Rehab assistance is not transferable as is the Section 8 voucher program and vouchers are attached to the particular rehabilitated unit and not the individual. Participants in the Mod Rehab program will only receive rental assistance if they are living in a Mod Rehab unit. Some Mod Rehab units are set aside for the elderly, homeless, or disabled.

The Shelter Plus Care Program is designed to promote permanent housing with supportive services to persons with disabilities coming from the streets and emergency shelters. Shelter Plus Care grants require a supportive services match equal to, or greater than, the Section 8 rental assistance award.

Resources

The *U.S. Department of Housing and Urban Development (HUD)* is responsible for administering the various federally based housing programs.

- The office of Public and Indian Housing (PIH) offers information and resources on the Housing Choice Vouchers (Section 8) program. Information can be found at
<http://www.hud.gov/offices/pih/programs/hcv/index.cfm>
- The office of Housing administers the Section 811 Supportive Housing for Persons with Disabilities program. Information can be found at
<http://www.hud.gov/offices/hsg/mfh/progdesc/disab811.cfm>
- The office of Community Planning and Development administers the Shelter Plus Care Program (S+C) program. Information can be found at
<http://www.hud.gov/offices/cpd/homeless/programs/splusc/index.cfm>

Collaboration with Department of Rehabilitation. For many persons with psychiatric disability, employment is not only a goal of treatment but also an aspect of treatment. Work improves self-esteem, provides financial security, contributes to a personal identity, and gives an opportunity for the individual to make a meaningful contribution to the community.

Many consumers have received the assistance and support needed to become successfully employed through collaborative efforts of mental health providers and the State Department of Rehabilitation. Despite these collaborations, there continues to be many barriers to achieving the successful entry or re-entry of consumers into the workforce.

It is the responsibility of the Department of Rehabilitation to provide vocational and employment related services to all people with disabilities. Despite this responsibility, there have been many difficulties obtaining these services.

Opportunities. Develop task forces and workgroups to focus on barriers to employment. These groups should involve members of California Mental Health Cooperative Programs, the Department of Rehabilitation, local pre-vocational training programs, mental health services providers, local volunteer centers, and local employers.

Examples.

California Mental Health Cooperative Programs provide collaborative employment services to assist people with severe disabilities to enter or re-enter the workforce. These community-based collaborations between local county mental health agencies and Department of Rehabilitation (DOR) field offices provide improved access, specialized employment services, and mental health supports. The Cooperative Programs adhere to the core values of consumer career choice, comprehensive service linkages, job placement in competitive and integrated employment, reasonable accommodations, and pro-active ongoing support.

The partnership between public mental health agencies and vocational rehabilitation provides for a wide range of individualized services that are delivered through 25 cooperative agreements. Services are consumer-driven so that consumers are central to all decision-making and service selections. Services include, but are not limited to, counseling and guidance, coordination in getting services from other agencies, vocational exploration, benefits planning and counseling, specialized employment assessments, college and university education, vocational training, job search and placement assistance, transportation, tools and equipment, work clothing, and on and off the job support.

California's One-Stop Career Centers are a collaborative that connects individuals to employment, education, and training services provided through local, state, and federal programs. Certain One-Stop Career Centers have complete employment, training, and education partners and their programs on-site, while others have only selected partners and some programs may be off-site. Some of the One-Stop Career Centers are referred to as "kiosks." These locations are self-service and have no staff available for assistance. A directory of the One-Stop Career Centers is available at www.edd.ca.gov/one-stop/osfile.pdf. All persons are welcome to use the One-Stop Career Centers including people with disabilities and limited English speaking ability.

Resources

California Department of Rehabilitation
<http://www.rehab.cahwnet.gov>

The California *Employment Development Department (EDD)* provides a direct link to job placement and referrals, unemployment insurance, disability insurance, employment and training, labor market information, payroll taxes, and more. <http://www.edd.ca.gov>

Collaboration with health providers. Individuals with severe and persistent mental illness have higher morbidity and mortality rates than the general population. This is a result of factors directly related to their illness such as side effects of medication - including diabetes and obesity - and

*Caring for
The Whole
Person*

factors related to life style including homelessness, substance abuse, smoking, and difficulty accessing preventive care. In order to assist clients to access health services it is important to know where and how they can receive the array of services needed.

Public Health Departments work in partnership with the community to ensure the optimal health and well-being of all members of the community. In collaboration with medical service providers, other county departments, city agencies, community-based organizations, schools, civic groups, and religious organizations, the Public Health Department addresses a myriad of health and safety issues that impact individuals and the community. Some of the services provided which can benefit clients of the mental health system include immunization assistance (including TB testing), alcohol and drug programs, health care at County health centers, information on free and low

cost health care services, prenatal services, information on dental programs, AIDS information and testing.

Federally Qualified Health Centers (FQHCs) accept Medicare and MediCal and provide primary care services for all age groups. These clinics, which receive enhanced reimbursement, are located among a population or area that is underserved. FQHC's must provide preventive health services on site or by arrangement with another provider. Other services that must be provided directly by an FQHC or by arrangement with another provider include dental services, mental health and substance abuse services, and transportation services necessary for adequate patient care, hospital, and specialty care. A mental health agency or program can provide basic health care at their site by becoming a satellite clinic of a FQHC. Typically, this will include basic services by a family nurse practitioner, lab services, and referral to the main clinic for specialized services.

Opportunities.

1. Become a satellite clinic to a Federal Qualified Health Center (FQHC). A mental health agency or program can negotiate with the FQHC to provide basic health care at their site by becoming a satellite clinic. Typically, this will mean access to basic services by a family nurse practitioner, lab services, and referral to the main clinic for specialized services.
2. Develop an agreement with a nursing program to provide basic health services on site by both nurse practitioners and rotating nursing students.

Example.

Mental Health Association of Los Angeles, Project Return: The Next Step.

PR: TNS's Wellness Centers (located in Long Beach and South Los Angeles) blend physical and mental health care strategies to help individuals achieve and maintain healthy lifestyles. The centers offer awareness classes on living with chronic health conditions, sponsor support groups to help individuals build a peer network, provide goal-oriented counseling, and train individuals to become peer counselors.

Collaboration with Educational Institutions. In order for the transformational vision of the MHSA to be realized, staff will need accurate information about recovery from mental illness, believe that it is possible, be trained in psychosocial rehabilitation, and understand the value of getting out of their offices and into the community.

Unfortunately, the body of knowledge relevant to the work of the public mental health system is seldom taught in either undergraduate or graduate programs that focus on the human services. As the system shifts in how we approach healing there must be an accompanying shift in how we train healers.

Opportunities. A qualified and diverse work force, trained in supporting recovery, wellness, and cultural competence, is key to the provision of quality mental health services. One way to avoid disengagement between educational and training programs, mental health providers and consumers is to create forums where collaboration can occur.

Examples.

CalSWEC II. One model of collaboration between mental health providers and educational institutions is the California Social Work Education Center (CalSWEC II). In this effort, faculty from Schools of Social Work and professionals from Mental Health Agencies throughout California developed a set of competencies for social work practice in mental health, which are relevant to public mental health practice today.

Bay Area Workforce Collaborative. The Bay Area Workforce Collaborative is a working group of consumers, educators and providers of mental health services. The goal of the Collaborative is to develop a diverse, culturally competent, recovery-oriented workforce. Activities of the group include:

- Development of promotional materials about the Collaborative
- Sponsorship of regional conferences on undergraduate and graduate level internships
- Promotion of the CASRA psychosocial rehabilitation curriculum and the national certification of Certified Psychiatric Rehabilitation Practitioners
- Facilitation of collaborative trainings by the Departments of Mental Health and Rehabilitation
- Support for the development of the Life High School Academy mental health program

Psychosocial Rehabilitation Curriculum. Educational opportunities, specifically designed to train individuals in psychosocial rehabilitation, have been developed with input from mental health providers, consumers, and families. The California Association of Social Rehabilitation Agencies (CASRA) has developed a 5-course curriculum in recovery-oriented, psychosocial rehabilitation practice. Designed for implementation at the community college level, it is also used as the basis for in-service training and has been adapted for use in masters of social work programs.

The coursework is competency-based and was developed through a DACUM (developing a curriculum) process that uses a group of expert practitioners to define work tasks. The process identified the core competencies needed for a person to work effectively. An advisory committee comprised of representatives from all the statewide mental health stakeholder groups reviewed the competencies.

Human Services Certificate Program at Pasadena City College. Pacific Clinics has worked closely with Pasadena City College to develop several certificate programs including a certificate in case management.

College of San Mateo, Certificate in Psychosocial Rehabilitation. The College has recently initiated a PSR certificate to add to an array of related certificates in human services. What is also unique about the CSM program is the strong partnerships with local employers, Department of Rehabilitation and the presence of a supported education program operated by Caminar.

Re-training programs. Educational institutions can be involved in re-training efforts as well. Courses in psychosocial rehabilitation can be offered for college credit or continuing education hours. Courses can be offered on-site, on campus, or via distance learning formats.

Sample Classes from the PSR Curriculum

- PSR Assessment
- Person-centered Planning
- PSR Interventions I
 - Outreach
 - Promoting problem-solving capacities
- PSR Interventions II
 - Teaching skills
 - Developing leadership and self-help skills
- PSR Interventions III
- Community Resources
- Advocacy

Collaboration with Law Enforcement. Every year, thousands of people with psychiatric disabilities are arrested because of behavior stemming from their illnesses. Most of these men and women would be more effectively and appropriately helped through the provision of quality mental health services. Nonetheless, many will serve a sentence and, upon release, will be left without access to the services and supports critical to breaking the cycle of recidivism.

While developing collaboration between mental health and law enforcement has proven to be an effective way to address this problem, it presents a number of challenges. Police departments need to acknowledge that the problem of mental illness in their community exists, recognize that there are alternative solutions to arrest and incarceration, and make collaborating with mental health a priority.

Opportunities. Throughout the United States and in many communities in California, mental health agencies and law enforcement departments have joined in a collaborative undertaking to affect this problem. These partnerships reflect a commitment by both agencies to achieve greater public health, to decrease stigmatization of person diagnosed with mental illness and to develop alternatives to incarceration for problematic behavior. There is substantial evidence that these partnerships advance public safety, leverage limited resources, and lead to better outcomes for persons with mental illness, their families and communities.

Goals of collaborative relationships between mental health and law enforcement include:

- Strengthening outreach efforts
- Providing long-term solutions
- Providing alternatives to incarceration/judicial interventions
- Linkage to mental health services
- Providing training and education to police as first responders to mental health crisis



Characteristics of successful partnerships include:

- A mental health outreach worker who rides with patrol officers on a regular basis

- Mental health personnel providing training in the field for police personnel
- Police departments assigning officers to ride with mental health outreach workers and encouraging officers to attend specialized training in dealing with persons with mental illness
- Police departments providing information on contacts with persons with mental illness
- Mental health outreach workers making contact with individuals, referring them to appropriate services, and making follow-up visits as needed
- Ongoing evaluation of the program

Program Benefits:

- Increased efficiency in identifying the needs of persons with mental illness, particularly those who are homeless
- Increased police officer knowledge in dealing with persons with mental illness
- Prevention of unnecessary arrests
- Reduction of 5150s (W & I code Sections)
- Reduction in the number of repeat contacts or calls for service
- Reduction in the amount of time police officers spend on mental health related calls
- Increased linkage to mental health services
- Reduced costs – both financial and human

Action Steps. Here are some action steps communities can take to facilitate collaboration between law enforcement and the mental health system.

- Identify a law enforcement department (city police, county sheriff or transit police) where community demographics reflect a high number of persons who are homeless or transient

- Develop a central contact person in that department who is interested in working with mental health and is willing to advocate with policy makers
- Identify an outreach worker from a mental health program to liaison with law enforcement
- Identify a program model that all parties agree to work with
- Develop training materials for use with law enforcement or contact the State Police Officer Standards and Training (POST) department for certified training modules
- Evaluate training materials already available for suitability such as the “Crisis Intervention Training” developed by the Memphis Police Department¹⁵
- Identify barriers to successful implementation of a mental health – law enforcement collaboration

Examples.

Orange County Health Care Agency AB 2034 Program

Annette Mugrditchian, LCSW, AB 2034 Coordinator (714) 517-6320

Westminster Police Department

Andrew Hall, Chief of Police (714) 898-3315

Santa Ana Police Department

Corporal Fortino Gallo (714) 565-4030

San Jose Police Department and Ventura Police Departments

Crisis Intervention Teams (CIT, “Memphis Model”)



¹⁵ The Memphis Police Departments’ Crisis Intervention Team is a unique collaboration between law enforcement, crisis intervention personnel, and community mental health. It is the first training model designed to give officers the tools to work with people in crisis and make every effort to divert them from jail. The program was established after a fatal incident involving a man experiencing severe psychiatric symptoms and has garnered the attention of many departments nationwide. For more information contact Major Sam Cochran at the Memphis Police Department or visit

<http://www.memphispolice.org/Crisis%20Intervention.htm>.

IV. Focus on Practitioners

*People do not care how much you know, until they **KNOW** how much you care.*



The cornerstone of recovery is having people in your corner who believe in you, see your strengths and capabilities and are committed to supporting the journey towards wellness and recovery.

Transformation of the mental health system to one based upon enhancing the quality of life and community integration of the people it serves requires a different skill set than that found in traditionally trained staff. It requires understanding the difference between a system based upon maintenance and stabilization as the goal versus one based upon community integration and recovery. This requires that we act in accordance with the responsibility to promote client choice and self-determination, enhance self-sufficiency and respect all rights inherent with being a citizen.

In the following, we present strategies for enhancing staff ability to work successfully in a recovery-oriented system. This includes the work of Mark Ragins, M.D., a psychiatrist at The Village Integrated Services Agency in Long Beach and a discussion of hope instilling strategies. The section concludes with a description of the core competencies found in psychosocial rehabilitation practice (PSR) and some ideas about training PSR psychiatrists.

A. 12 Aspects of Staff Transformation

“There is a lot of talk about transforming our mental health system into a consumer-driven recovery-based system, but very little talk about transforming staff to work successfully in this new system. Recovery programs, to this point, tend to rely on creating small counter-cultures with dynamic leadership, staff that are different or want to change, and new non-professional and consumer staff. Transforming existing programs with existing staff will require a proactively guided process of staff transformation to succeed. This paper describes 12 aspects of staff transformation.

1. Looking Inward and Rebuilding the Passion. Recovery work requires staff to use all of themselves in passionate ways to help people. It cannot be done effectively in a detached, routinized way. Recovery staff tends to be happier, more full of life, and more actively engaged. To achieve this, staffs need to look inwards to remember why our hearts brought us into this field in the first place. For many staff, our hearts have been buried under bureaucracy, paperwork, under-funding, frustrations, and burn out. Staff must be nurtured, encouraged to play and explore, to bring our lives into our work, and cherished for our individual gifts and hearts. Staff with hope, empowerment, responsibility, and meaning can help people diagnosed with mental illnesses build hope, empowerment, responsibility, and meaning. Administrative leadership must effectively promote their staff before further transformation can occur.
2. Building Inspiration and Belief in Recovery. Staff spends the vast majority of time and emotions on people who are doing poorly or in crisis. We neglect the stories of our own successes and our roles in supporting these successes. Staff needs to be inspired by hearing people tell their stories of recovery, especially the stories of people we have worked with and known in darker times. We also need to be familiarized with the extensive research documenting recovery and the concept of the “clinicians’ illusion” that gets in the way of us believing in this research. Ongoing experiences of people achieving things we “know are impossible” are crucial.
3. Changing from Treating Illnesses to Helping People with Illnesses Have Better Lives. Recovery staff treat “people like people” not like cases of different illnesses. The pervasive culture of medicalization is reinforced by the infrastructure. Goal setting needs to reflect quality-of-life, not just symptom reduction. Data on quality-of-life outcomes need to be collected. Treatment must be life-based, not diagnosis-based.



Assessments must describe a whole life, not an illness with a psychosocial assessment on a back page. Progress notes need to reflect life goals, not just clinical goals. Team staff meetings need to discuss practical problems of life.

4. Moving from Care-taking to Empowering, Sharing Power and Control. Staff has generally adopted a care-taking role towards people with a mental illness. We act protectively, make decisions for them because of their impairments, even force them to do what we think is best for them at times. Recovery practice rejects those roles, although many staff and mentally ill people are comfortable with them. Analogously to how parents must stop being caretakers for their children to become successful adults, staff must stop being caretakers for people we work with in order for them to recover. There are enormous issues around fear of risk taking, feelings of responsibility for the people we work with, and liability concerns that become involved as staff tries to become more empowering. There may also be personal issues around power and control. Most staff feels most efficient and effective when we are in control and people are doing what we want them to. Especially when facing repeated failures, or crises, frustration is likely to grow. We are likely to reject collaboration and want to take more power and control.
5. Gaining Comfort with Co-Staff with Mental Illness and Multiple Roles. Recovery requires breaking down the “us vs. them” walls. People with psychiatric disabilities must be included as collaborators, co-workers, and trainers. Working alongside people with mental illness as peers (not as segregated, second-rate staff) is probably the single most powerful stigma reducing and transforming experience for staff. For people with mental illness to recover and attain meaningful roles beyond their illness roles, staff needs to take on roles beyond our “illness treatment” roles. Programs can promote this transformation by creating activities like talent shows, cook-outs, neighborhood clean-ups, art shows, etc., where staff and people with mentally illness interact in different roles.
6. Valuing the Subjective Experience. Staff has been taught to observe, collect and record objective information about people to make reliable diagnoses and rational treatment plans. Recovery plans are collaborative. To achieve this collaborative partnership, staff must appreciate not just what is wrong with a person, but how that person understands and experiences what is happening. Knowing what it would be like to be that person, what they’re frightened of, what motivates them, what their hopes and dreams are, are all part of a subjective assessment. Charted assessments, “case conferences”

(shouldn't these be "people conferences"?), team meetings, and supervision all should value subjective understandings.

7. Creating Therapeutic Relationships. Recovery work emphasizes therapeutic work more than symptom relief. Our present system relies on illness diagnosis, treatment planning, treatment prescription, and treatment compliance. Staff can be interchangeable, professionally distant, even strangers, so long as the diagnosis, plan and compliance is preserved. Recovery work relies on the same foundation as psychotherapy: (1) an ongoing, trusting, collaborative, working relationship, (2) a shared, explanatory story of how the person got to this point, and (3) a shared plan of how to achieve the person's goals together. Staff needs to gain—or regain—these skills. Program designs must prioritize relationships so staff can create relationships.
8. Lowering Emotional Walls and Becoming a Guiding Partner. People repeatedly tell us that we are the most helpful when we are personally involved, genuinely caring, and "real." Psychotherapeutic and medical practice traditions, ethical guidelines, risk management rules, and personal reluctance come together against lowering emotional walls. Staff needs a lot of discussion and administrative support to change in spite of these strong contrary forces. To best support a person on their path of recovery, staff needs to act not as detached experts giving them maps and directions, but to actually becoming involved, walking alongside them as guides, sharing the trip. Staff's emotional and physical fears of the people we work with need also need to be dealt with in order to lower the walls.
9. Understanding the Process of Recovery. Staffs are familiar with monitoring progress as a medical process. We follow how well illnesses are diagnosed, treated, symptoms relieved, and function regained. We alter our interventions and plans based on our assessment of this process. Recovery work monitors a very different process - the process of getting well. Analogously to the grief process hospice works with, the recovery process can be described by a series of four stages: (1) hope - believing something better is possible, (2) empowerment - believing in ourselves, (3) self-responsibility - taking actions to recover, and (4) attaining meaningful roles apart from the illness. Where hospice staff help people die with dignity, recovery staff help people live with dignity. Staff members grow in their understanding of the recovery process and their skills in promoting recovery.

*Walking
The Path
Of Wellness
Together*

10. Becoming Involved in the Community. Recovery tries to help people attain meaningful roles in life. These roles will require them to be reintegrated into the community, to be welcomed and to be valued, to find their niches. Recovery cannot be achieved while people are segregated from their communities or protected in asylums. To support this, staff must work in the community. We can't be segregated from our communities or act solely as protectors in asylums. We need to be welcomed and valued and to find our niches. This is a substantial change for most staff and may trigger personal insecurities. Community development and anti-stigma work are important new programmatic and staff responsibilities.
11. Reaching Out to the Rejected. Recovery is being promoted, not just as a way of helping people who are doing well do even better, but also as a way of engaging with and helping people who do not fit well with the present system. Recovery programs have proven success with people with dual diagnoses, homeless people, jail-diversion people, "non-compliant" people, people with severe socio-economic problems, and people lacking "insight." Each of these people has different serious obstacles to engagement and treatment, and staff often has serious prejudices against them. A "counter-culture of acceptance" needs to be created to work with them. This often requires both an attitudinal change in staff and training in specialized skill sets. The system transformation will not be considered a success if we continue to reject these people in need.
12. Living Recovery Values. "Do as I say, not as I do" is never a good practice. When the walls and barriers are reduced and emotional relationships enhanced in a good recovery program, it's even harder to hide. Staff must live the values of recovery and be actively growing ourselves if we expect to be effective recovery workers. In recovery, the same rules and values apply to all of us.

By describing these 12 aspects of staff transformation, I have tried to create both a proactive curriculum for staff transformation, and a guide for recovery-oriented leaders to use in program design, supervision, and staff support."

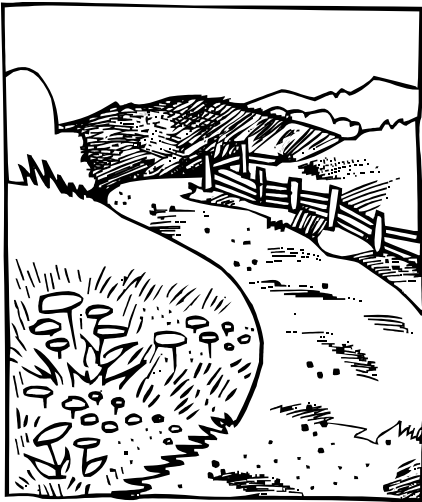
Resources

This excerpt is from Dr. Ragin's article *Proposition 63 Begins: Implementation Toolkit*. The complete text can be found at:

http://www.village-isa.org/Village%20Writings/writings_hp.htm

Mark Ragins, M.D. works at The Village ISA in Long Beach California. Descriptions of their renowned program and other writings of Dr. Ragins can be found on The Village's website.

<http://www.village-isa.org>



*Sharing the
Journey*

B. Hope Inspiring Strategies

"It is not our job to pass judgment on who will and will not recover from mental illness and the spirit breaking effects of poverty, stigma, dehumanization, degradation and learned helplessness. Rather our job is to participate in a conspiracy of hope."

Pat Deegan, Ph.D.



Mental health and rehabilitation practitioners routinely implement various hope-inspiring strategies, though often, these interventions are not connected with the goal of instilling and maintaining hope in the client. It is important to integrate hope-inspiring strategies with practitioners' understanding of the dynamics of hope and despair and with their own beliefs regarding the potential for recovery from a challenging psychiatric disability.

The first type of hope-inspiring strategies reflects the healing potential of supportive relationships. One of the most powerful hope-inspiring strategies included in this group is the ability of the practitioner to promote the person's potential and strengths through maintaining a strong belief in the individual, even during times of crisis and temporary deterioration. These hope-inspiring strategies are relevant to any helping relationship independent of the practitioner's professional discipline.

Hope-Inspiring Strategies

The second group of hope-inspiring strategies focuses on increasing the person's coping skills, self-esteem, and confidence in their personal strengths.

The third group of hope-inspiring strategies facilitates the individual's ability to recognize and use a variety of external resources that can have a positive impact on the process of recovery.

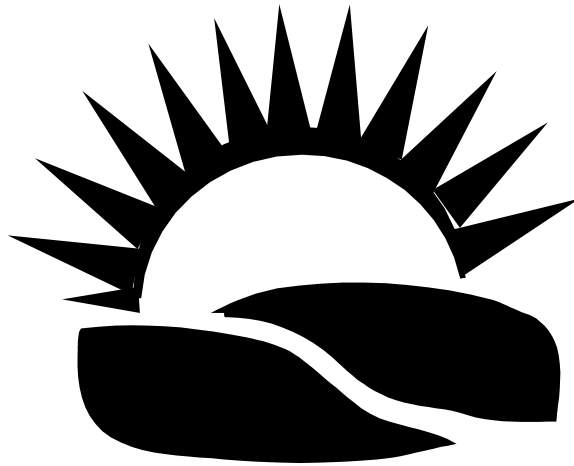
The following table presents the work of Dr. Russinova who has done a great job of describing types of hope-inspiring strategies.

Types of Hope-Inspiring Strategies

<i>Hope-Inspiring Strategies for utilizing Interpersonal Resources for Recovery</i>	<i>Hope-Inspiring Strategies for Mobilizing Internal Resources for Recovery</i>	<i>Hope-Inspiring Strategies for Utilizing External Resources for Recovery</i>
Believing in the person's potential and strength.	Helping the person to set and reach concrete goals.	Helping the person to connect to successful role models (i.e., persons at a more advanced stage of recovery).
Valuing the person as a unique human being.	Helping the person to develop better coping skills.	
Accepting the person for who he/she is.	Helping the person to recall previous achievements and positive experiences.	Being available when the person is in crisis.
Listening non-judgmentally to the person's experiences.	Using techniques for changing the person's negative perceptions of events and self.	Helping the person to manage the illness through medication.
Tolerating the uncertainty about the future developments in the person's life.	Helping the person to accept limitations.	Supporting the person's involvement in educational programs.
Accepting the person's decompensations and failures as part of the recovery process.	Helping the person to accept failures and learn from them.	Educating consumers regarding their illness.
Tolerating the person's challenges and defects.	Helping the person to grieve for the losses experienced because of the mental illness.	Helping the person to join self-help groups.
Trusting the authenticity of the person's experiences.	Helping the person to make sense of the suffering related to his/her mental illness.	Facilitating the family support for the person.
Expressing a genuine concern for the person's well-being.		Providing support regarding the person's housing situation.
Using humor appropriately.	Helping the person to find personal meaning and purpose in life.	Supporting consumers in obtaining and keeping employment.
	Supporting the person's spiritual beliefs.	

Resources

Russinova, Z. (1999). Providers' hope-inspiring competence as a factor optimizing psychiatric rehabilitation. *Journal of Rehabilitation*, 16(4), 50-57.



Hope is Fundamental to Recovery

C. Competence in Psychosocial Rehabilitation

The public mental health system in California is severely challenged by the need for more staff, more ethnically and culturally diverse staff, and staff with a different skill set than traditionally found in the mental health professions.

The mental health field has advanced from a strictly medical model orientation, with an emphasis on pathology and medications, to a psychosocial rehabilitation and recovery-orientation emphasizing improving the quality of life of people living with mental illness, not just treating the symptoms.

In 2002, the California Association of Social Rehabilitation Agencies (CASRA) completed a 4-year project to delineate the core competencies of psychosocial rehabilitation practice and to develop a curriculum that could be used in either academic or employment settings. The project included a definition of a Psychosocial Rehabilitation Practitioner.¹⁶

Definition of Psychosocial Rehabilitation Practitioner. Psychosocial Rehabilitation (PSR) Practitioners believe and convey hope that people can change and improve. Working in the context of an agency, a mental health service system, a community, and the cultural environment and world view of persons served, practitioners partner with people who have psychiatric disabilities to develop and achieve self-selected and self-directed goals for recovery. Practitioners adhere to ethical standards and the right of choice, as they apply psychosocial rehabilitation principles to their work.

Psychosocial Rehabilitation Practitioners are competent to:

- Respond to the culture/ethnicity of person they serve
- Partner with the consumer to formulate a strengths assessment and assessment across life domains, i.e., family, friends, intimacy, housing, work, education, money, health, leisure, creativity and spirituality
- Partner with person with psychiatric disabilities to identify and address barriers that interfere with [or block] goal achievement

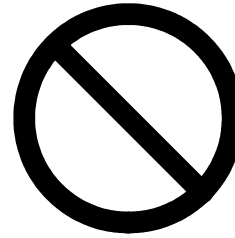
¹⁶ The competencies of PSR practitioners are delineated in full in the PSR Practitioner DACUM, conducted April 2001, Sacramento, CA

- Assess need for and provides access to other professional health, human, social, legal and financial services
- Partner with person to explore and evaluate choices and identify goals and options for services
- Participate as team members within a service delivery team and with the person and the person's support system
- Partner with the person's chosen service providers (including physicians), personal support system (including family members) and community resources
- Provide service coordination directly or participate with person's service coordinator
- Provide supportive counseling
- Provide skill training in accordance with a person's goals
- Assist person to garner support and access community resources beyond the formal helping systems
- Assist person to access self-help and alternative support and services
- Partner with person to develop resources to meet their needs
- Advocate for person to secure resources, supports and benefits
- Assist person in accessing and utilizing non-mental health services and supports, thereby reducing dependency on the mental health system
- Provide outreach and engage with people who do not use but may benefit from services and support
- Engage the community in supporting people with psychiatric disabilities
- Advocate for equal treatment and services for people with psychiatric disabilities



Psychosocial Rehabilitation Practitioners do not:

- Provide psychotherapy
- Formulate diagnoses
- Practice independently
- Recommend, prescribe or administer medications



Psychiatric Rehabilitation Practitioner Credential

In recognition of the unique knowledge and skills that define recovery-oriented practice, the United State Psychiatric Rehabilitation Association (formerly the International Association of Psychosocial Rehabilitation Services), has developed a national credential in PSR practice. The Certified Psychiatric Rehabilitation Practitioner is a test-based credential that has been recognized in twelve states by regulations defining and/or qualifying mental health practice.

The designation is unique; while it does measure and recognize specific skills in the area of psychosocial rehabilitation, the qualifications needed to take the exam are a broad and versatile mix of experience and education.

As an example, persons with a high school diploma or GED can qualify for the exam with two years experience in the field and 60 hours (or 6 academic units) of specialized training.

Eligibility Requirements

Academic Preparation	PSR Experience	PSR Training (post-degree)
Graduate Degree in PSR	6 months	None required.
Graduate Degree in Mental Health	1 year	None required.
Graduate Degree in an Unrelated Fields	1 year	60 in-class hours of training OR 6 college-level credits in PSR.
Bachelor Degree in PSR	6 months	None required.
Bachelor Degree in Mental Health	1 year	None required.
Bachelor Degree in an Unrelated Field	1 year	60 in-class hours of training OR 6 college-level credits in PSR.
Associate Degree in PSR	1 year	None required.
Certified in PSR	1 year	None required.
Associate Degree (other than PSR) OR High School Diploma (or GED)	2 years	60 in-class hours of training OR 6 college-level credits in PSR

D. Training PSR Psychiatrists

By Mark Ragins, M.D.

Editor's Note: Instead of offering excerpts from the following, we thought you might enjoy the unabridged version.

Psychiatrists who are working with people with persistent serious mental illnesses will often want to include rehabilitation as part of their patients' treatments. Most commonly, the concept is that first the psychiatrist and/or therapist will clinically treat the patient to stabilize their illness and their symptoms and then they will be ready for rehabilitation. Numerous pitfalls exist with this approach including prolonged searches for "readiness", chronic "patienthood" and dependency, decreased self confidence and willingness to take risks to grow, over interpretations of "normal" life as symptoms, settling for disability and its "benefits", ongoing resentments, frustrations and anger, "noncompliance", "survivors" not of illnesses but of the treatment system itself, etc.

I have lived and promoted an alternative approach of the psychiatrist being fully integrated into the rehabilitation program and recovery community along with the person we're working with, using our skills not as preparation for rehabilitation and recovery but as tools of rehabilitation and recovery. I've become one of the very few psychiatrists who's an active member of rehabilitation agency associations. When I describe my role to these agencies, they're always interested, but say that their psychiatrists are nothing like me; they're entirely symptom focused, they treat people as patients, they're not part of the team, etc. Frequently, they even have groups and role playing around how to talk with your psychiatrist as though psychiatrists are another insensitive part of "them", the outside system. A new case manager at our program complemented me saying she was surprised at how well I talked with a new lady, opening her up, making plans, treating her respectfully since she's always experienced psychiatrists as bad, distant and insensitive.

I've found that it is true that to be part of a rehabilitation/recovery program, I've had to change many traditional ways of working that I had. It is also clearly true that very few psychiatrists have ever had substantial exposure to, training in, or work in rehabilitation/recovery settings. It was entirely missing from my residency education. I have tried to contribute to teaching psychiatry residents about rehabilitation and recovery in a variety of ways and I'd like to share some of my thoughts and experiences.

I've begun viewing teaching rehabilitation and recovery as a process analogous to teaching psychotherapy (I realize that this too is a dying, neglected part of psychiatrists' training today, but I'm just old enough to have been taught to be a psychotherapist and to know it's different although compatible with and actually synergistic with, being a doctor). The psychosocial rehabilitation model has distinct characteristics of the kind of helping relationship that is desired, predictable paths to recovery, techniques to promote it, and visions of the desired outcomes. (Once again different from, but compatible, even synergistic with medical training.)

The kind of helping relationship in the psychosocial rehabilitation model is really quite different from the traditional doctor-patient relationship and probably the most difficult transition for residents to make. The relationship is not centered around a powerful helping professional taking care of, protecting, and helping a weak, vulnerable, damaged patient. It is centered around helping someone with a mental illness define and pursue their own goals and life visions, empowering and educating them to learn to overcome their own illnesses, and encouraging risk taking and growth, learning from natural consequences and failures. It is far more like the role of coach than of doctor. Most of us naturally make this change when we are trying to help a friend or another doctor, treating them as colleagues or collaborators rather than as patients. However, we have been carefully trained not to be "unprofessional" in our daily work. In addition, people with serious mental illness are often very hard for us to view as potential colleagues or friends.

There are also frequently other reasons for not departing from the medical model doctor role. One resident told me she wasn't yet comfortable enough being a doctor to give it up and besides she just wasn't comfortable eating lunch with a mentally ill patient. Another one from a foreign country said he didn't think he could get respect from American people without a strong doctor role. Another one was the 12th male doctor in his family and had been groomed his whole life to be one.

On the other hand, a medical model role is simply unsuited to building a rehabilitation relationship with many people with serious mental illnesses. Before we seek to further imitate our medical colleagues we should remember how much difficulty they usually have forming working relationships with people with serious mental illnesses. Learning how to treat neurochemical imbalances is in no way adequate to meeting the daily challenges of our work. Once residents do make the change to a collaborate role, which seems to take about 6 months, they describe feeling liberated, more in touch with the reasons they became a psychiatrist, closer to the people they work with, and more effective.

The second difficult adjustment is that unlike the medical model where the effective treatment modality is the doctor-patient (or therapist-client) dyad, in a psychosocial rehabilitation program the effective treatment modality is the recovery community itself. The staff, members, volunteers, and other neighborhood participants are all part of everyone's recovery. Once again this is somewhat analogous to the old psychotherapeutic milieu. The psychiatrist is just one member of the community, although potentially a very important one, and our contact with the member needs to be coordinated with the rest of the team and even the entire program's community to be effective. As one resident recently put it, he's been on teams before where several staff each work with the same patient, but never where they actually worked together as they do here. We're far closer to interchangeable generalists than a multidisciplinary team of specialists. Once psychiatrists leave hospital and university settings, it is rare to find hierarchical medical model teams where the psychiatrist gives orders. Residents should be trained in other team models.

The actual techniques of rehabilitation also require a paradigm shift to use. The process is not one of treating illnesses, while someone else handles the rest of what's needed. It's one of helping people in their entirety. One resident said instead of learning how to be a bad social worker, he learned how to be a good doctor. The focus is not on relieving symptoms or suffering, but on promoting personal growth and change. Teaching someone how to use medications to help gain control of their illnesses is often more important than the actual symptom relief. Helping someone find their lost child, getting them SSI, or persuading them to go to a substance abuse program are often more important than assessing their illness.

Once that paradigm shift is made the actual techniques are not that difficult to learn. The essential techniques of psychosocial rehabilitation include: 1) helping someone form a vision of their own recovery, 2) training in goal setting and accomplishment, 3) forming emotional connections with people with severe mental illnesses, 4) treating people with respect, 5) empowering people, 6) giving hope, 7) teaching self-management of illnesses, 8) various in-vivo skills training and modeling, 9) social network building, and 10) community integration. They are generally not taught in psychiatric residency programs. Nonetheless, they are very helpful to the people we work with.

The outcomes of our work are another important focus. Most residents are very discouraged in their work with people with serious mental illnesses. They've predominately been exposed to either revolving-door hospital patients or medication maintenance clinics aimed at prolonged stabilization. One is frustrating and the other stagnating. In a rehabilitation setting, residents can share people's recoveries first hand. Dramatic quality of life improvements occur regularly and hopefulness and job satisfaction builds.

Residents who work in community settings as part of their residency repeatedly choose careers working in those settings. Careful, long term, longitudinal studies of outcomes of schizophrenia repeatedly are more hopeful than we are. This is especially true when quality of life outcomes are used instead of strictly clinical outcomes. We want residents to evaluate their work on if people have improved quality of life, increased community integration, increased self management of illness, and increased productivity and role performance. Once again, we're trying to help people, not just treat illnesses.

In conclusion, I have tried to present and teach a comprehensive view of psychosocial rehabilitation. I see it not as an adjunct to clinical treatment, but as an integrating model. It includes a clear vision of the therapeutic relationship, techniques, and desired outcomes in a far more relevant and meaningful way than a strictly medical model for people with serious mental illnesses. As such, it deserves to be included as an important part of psychiatric residents' training.

V. Focus on Services

I believe that recovery is only possible in the absence of attack, force, and coercion, that health happens when the greatest dignity and respect is afforded to each human life.

Laura Prescott ~ Worthington, MA



The goal of services is to provide individualized approaches to helping consumers develop a network of supports in the community. The task is not replicate opportunities available in the community but to provide the support necessary to participate in community life.

A range of services, sharing a common goal of enhancing quality of life, can be articulated as starting points towards community support services.

A. **Supported Housing**

Homelessness in California remains a pressing social problem. On any given day, there are over 360,000 homeless persons. Between one to two million Californians experience homelessness during any given year. At least a third of those people living on the streets and in shelters have a severe and persistent mental illness.



Without a stable place to live and a support system to help them address their underlying problems, most people who are homeless bounce from one emergency system to the next – from the streets to shelters to public hospitals to psychiatric institutions and detoxification centers and back to the streets – endlessly. Referred to as the "revolving door syndrome," the cost, in human and economic terms, is extreme.

Opportunities. Supported housing is proven to help people who face the most complex challenges – individuals and families who are not only homeless, but have very low incomes and serious issues that may include substance use and mental illness.

It costs essentially the same amount of money to house someone in stable, supportive housing as it does to keep that person homeless and stuck in the revolving door of high-cost crisis care, emergency housing, and

incarceration. In addition, studies indicate that supported housing residents have:

- Decreases of more than 50% in tenants' emergency room visits and hospital inpatient days; decreases in tenants' use of emergency detoxification services by more than 80%; and increases in the use of preventive health care services
- Increases of 50% in earned income and 40% in the rate of participant employment when employment services are provided in supportive housing
- A study of 900 homeless people with mental illness provided with supportive housing found 83.5% of participants remained housed a year later, and that participants experienced a decrease in symptoms of schizophrenia and depression

Key ingredients in Supported Housing include:

- Consumer either owns a home or has a lease
- Housing is integrated into the community
- Housing is affordable
- Services are voluntary and not contingent on receiving other services
- Consumer has a choice
- Services are community-based
- Services are available 24 hours a day
- There is no live-in support staff.

Action Steps.

- Create a work group consisting of mental health providers, housing staff, consumers and family members to evaluate housing opportunities and make recommendations for housing development.
- Create a staff position of "housing coordinator."

Examples.

Name: Paseo Glenn Apartments
Location: San Diego County
Owner: The Association for Community Housing Solutions (TACHS)
Service Provider: TACHS and AB 2034 Program
Number of Units: 14
Population Served: Homeless, adults with mental illness
Funding Sources: Multifamily Housing Program, Supportive Housing Program, Affordable Housing Program (FHLB),¹⁷ Home funding (LIIF and CSH loans to acquire)¹⁸

Name: Stony Point Commons
Location: Sonoma County
Owner: Community Support Network (developed by Burbank Housing and Community Development Corporation of Santa Rosa)
Service Provider: Community Support Network
Number of Units: 16
Population Served: Homeless, adults with mental illness
Funding Sources: Supportive Housing Program, Affordable Housing Program, Local Redevelopment Agency, (CSH loan to acquire)

Resources

Corporation for Supportive Housing
<http://www.csh.org>

Nonprofit Housing Corporation of Northern California
<http://www.nonprofithousing.org>

Southern California Association of Nonprofit Housing
www.scanph.org

¹⁷ FHLB – Federal Home Loan Bank

¹⁸ Liif - Low Income Investment Fund; CSH – Corporation for Supported Housing

B. Supported Education

In recent years, people with disabilities have formed a steadily increasing presence on college campuses across the country. Federal legislative initiatives have enhanced the development of specialized support services and opened the doors of colleges and universities to these students, the majority with either physical or learning disabilities.

Until recently, those with psychiatric disabilities did not attend college, despite their inclusion in the legislation. Their omission is significant, given that psychiatric disabilities often severely disrupt the normal process of educational and vocational development, and start many on a path of educational underachievement or failure, underemployment, or unemployment.

People who are minority group members as well as those with psychiatric disabilities are at even greater risk for compromised educational opportunities and limited access to vocational placement.

Individuals with psychiatric disabilities are returning to post-secondary education in an effort to regenerate lost opportunities and resume their vocational development. Their efforts have been increasingly buoyed by a growing number of successful supported education (S. Ed) programs, all of which have had a positive impact on both the educational status and the psychological functioning of student participants.



These programs represent creative applications from the field of psychosocial rehabilitation. The services, supports, and technology developed via the practice of psychosocial rehabilitation readily lend themselves to the art and science of helping consumers assume their rightful roles as students.

Opportunities. Education is an appropriate rehabilitation tool to help individuals achieve goals they have chosen (e.g., particular jobs, technical skills, or careers), as well as an appropriate setting for psychiatric rehabilitation practice.

Education offers normalized and valued activities on college campuses, in classrooms, and roles as students. In fact, education is an appropriate rehabilitation goal in and of itself (conferring status and skills that are desirable, while simultaneously boosting self-confidence and self-efficacy).

Supported education programs and services follow the psychiatric rehabilitation model of choose-get-keep; assisting individuals to make

choices as to desired paths for education and training, helping them to get into an appropriate education or training program, and assisting them to keep their student status within that program until their goals are achieved.

Supported education programs accomplish these goals by providing individuals with the knowledge and skills they need to help them achieve success, by providing assistance and support to them in their interactions with post-secondary educational settings (including coping and problem-solving abilities), and by intervening with schools and ancillary support services as needed to support these individuals.

Supported education is crucial in the effort to employ more consumers in the mental health system. While consumers should be encouraged to pursue an education at all levels, from community college through post graduate education, certificate programs in psychosocial rehabilitation, human services and addiction studies have particular appeal when they are practical, relevant and applicable to the work site.

Action steps.

- **Assess educational opportunities** in the community including high school academies, adult education, certificate programs, community colleges, and private and public universities,.
- **Form a work group.** If no formal supported education program exists, form a work group of educators, mental health professionals, employers, consumers, and family members to develop a plan for providing supports for education.
- **Access training resources and consultation** which are available through the Mental Health/Department of Rehabilitation Co-op.
- **Provide training opportunities for staff.** This training would include recovery principles and the relationship to supported education, an overview of models (e.g. choose, get, keep) and a review of local resources.
- **Provide Supported Education (S. Ed)** training and technical assistance to Disability Support Service (DSS) practitioners to better address the service needs of students with psychiatric disabilities.

Examples.

Mental Health/Department of Rehabilitation Coops

<http://www.rehab.cahwnet.gov>

Provides free training and technical assistance on a variety of topics related to supported education and employment.

<http://www.rehab.cahwnet.gov>

Caminar (San Mateo county)

<http://www.caminarinc.org>

Caminar is a non-profit organization that provides an array of rehabilitation and recovery-oriented services. Caminar provides supported employment services and supports in the College of San Mateo (CSM)'s "Transition to College" program. The ToC program is a partnership between CSM, Caminar and local consumer groups. The college provides academic and disability related counseling, career education, accommodations and peer support. Caminar contributes staff to support students on the college campus, co-instructors for career classes, consultants to college staff, and trainers/supervisors for peer counselors.



Important Tools for Recovery

Resources

Mowbray, Carol. (2002). *Supported Education and Psychiatric Rehabilitation: Models and Methods*. Linthicum, MD: United States Psychiatric Rehabilitation Association

Unger, Karen (n.d.). Supported education, an idea whose time has come. *The Journal. NAMI-CA*. Volume 8, issue 2.

C. Supported Employment

Work is at the very core of life for most people in that it provides financial security, personal identity, and an opportunity to make a meaningful contribution to community life. Individuals with severe psychiatric disability, however, have traditionally been denied the opportunity of working in the community. If we are to create a system that promotes and supports recovery, it is critical that consumers be given every opportunity to enter and succeed in the world of work.

There are 3 million working-age adults with severe mental illness in the nation's communities, of whom 70%-90% are unemployed. (A rate higher than for any other group of people with disabilities.)

A diagnosis of mental illness is not a reliable indicator that someone cannot work: indeed, many people are able to work successfully despite their symptoms.

On-the-job accommodations that make it possible for people with mental illness to succeed at work are relatively straightforward and inexpensive to provide.

The great majority of people with a mental illness want to work: recent surveys report that approximately 70% rank work as an important goal.

Successful careers for people with serious mental illness reduce the use of costly mental health services and hospitalizations.

Innovative rehabilitation programs are placing more than 50% of their clients into paid employment.

Employers who have hired persons with serious mental illness in the past are generally very positive about their experiences.¹⁹

¹⁹ See the following:

Ridgeway, P. & Rapp, C. (1998). *The active ingredients in achieving competitive employment for people with psychiatric disabilities: a research synthesis*. Lawrence, KS: Commission on Mental Health and Developmental Disabilities. (Critical Ingredients Series) and

Shepherd, G., Murray, A., & Muijen, M. (1994). *Relative values: the different views of users, family carers, and professionals on services for people with schizophrenia*. London: Sainsbury Centre for Mental Health.

Any discussion of employment of persons with psychiatric disabilities must begin with an acknowledgement of the Club House movement. The cornerstone of the clubhouse movement is its focus on the work-ordered day and its emphasis on the development of employment opportunities where persons with long-term psychiatric disabilities can begin to see and experience the world of work as something open to them. The initial program, Fountain House, was established in New York in 1948. Since then, there are over 1000 clubhouse programs providing opportunities for socialization and transitional employment. It should also be noted that the concept of "membership" that forms the basis of the Village Integrated Services Agency in Long Beach is derived from the clubhouse model.

In California, legislative initiatives have promoted the need to address vocational development as early as 1978 (Community Residential Treatment Systems Act). Section 5670 of the California Welfare and Institutes Code refers to pre-vocational and vocational programs as part of a rehabilitation focus.

Section 5690 of the California Welfare and Institution Code states: "It is the intent of the Legislature to encourage the establishment in each county of a system of community vocational rehabilitation and employment services, for persons with serious psychiatric disabilities. It is further the intent of the Legislature that there be a range of available services whenever possible in each county based on the principle that work is an essential element in the local mental health treatment and support system."

Opportunities. Whenever possible, a vocational program that offers a variety of employment options to consumers is ideal. It is critical that the vocational program have strong connections both with the community of employers as well as health and mental health services, operates from a recovery perspective that emphasizes client choice and cultural competence, and provides peer support. Services offered should include assessment of work skills and deficits, benefits counseling, help with resume writing and interviewing, a variety of opportunities for work experience, job development, job placement, and on-going support from both staff and peers.

The absence of a stand-alone vocational program in any area should not impact the consumer in their desire to enter and succeed in the work force.

There are distinct advantages to creating the role of "employment specialist" on a service provision team. In this model there is generally better

collaboration between various service providers and vocational services, services are individualized and based on the consumers' needs and wants.

It is also useful to have a "job developer" to locate job openings, contact employers, visit job sites, and meet with managers or personnel directors of various businesses. As with a supportive education program, it is critical that services be culturally competent and includes both consumers working in the program as well as peer support.

Action Steps.

- **Create county-wide or area-wide task force.** This task force would review employment services, identify gaps, and make recommendations for additional program development.
- **Identify key persons in employment services** from mental health, rehabilitation, and mainstream workforce service providers (i.e. Employment Development Department, One Stop operators, Social Security) to meet periodically to coordinate services.
- **Provide training opportunities for staff.** The training would include recovery principles and the relationship to employment services, an overview of models of vocational services (e.g. choose, get, keep), and a review of local resources.

Examples.

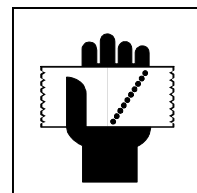
Mental Health/Department of Rehabilitation Coops

<http://www.rehab.cahwnet.gov>

Twenty-two counties participate in this program which blends mental health and department of rehabilitation funds. In a report dated February 28, 2005, Sacramento, Monterey, and Humboldt counties had the highest percentage of successful placements.

Ticket to Work

<http://www.yourtickettowork.org>



This program has recently been implemented in California. SSI and SSDI qualified recipients receive a "ticket" which they can take to a provider in the Employment Network (EN). Programs are reimbursed when the consumer reaches certain milestones, with the full amount paid only when the consumer achieves competitive employment (Substantial Gainful Activity). Drawbacks include the limited reimbursement and managing agency cash flow.

Exemplary Programs.

MHA-LA: The Village Integrated Services Agency (Los Angeles County)

<http://www.village-isa.org>

Vocational Services are integrated into personal service plans, psychiatric care, substance abuse recovery, housing assistance, financial services, and community involvement.

Crossroads Employment Services (Sacramento County)

<http://www.crossroadsdiversified.com>

Provides employment services that get people back to work and support the businesses that hire them.

Alliance for Community Care (Santa Clara County)

<http://www.alliance4care.org>

ALLIANCE Employment Services provide a comprehensive array of counseling, support and resources that assist adults with a mental illness that are interested in returning to work. Services offered include vocational assessment, employment preparation, support with training and education, job search and placement, and job retention services.

Meaningful Work
is Healing



Resources

Disability Benefits 101 provides comprehensive information about working with a disability in California. This site covers both state and federal issues that affect all workers with disabilities.

<http://www.disabilitybenefits101.org>

Job Accommodation Network is a free service of the Office of Disability Employment Policy, U.S. Department of Labor. JAN provides information to employers and consumers in developing effective reasonable accommodations and provides technical assistance on the ADA in regards to employment.

<http://www.jan.wvu.edu>

Network on Employment, formally the Association for Persons in Supported Employment is a membership group that provides advocacy and training in the integration of persons with disabilities into the workforce.

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

The Red Book, published by the Social Security Administration, serves as a general reference source about all the employment-related provisions of Social Security Disability Insurance and the Supplemental Security Income Programs for educators, advocates, rehabilitation professionals, and counselors who serve people with disabilities.

http://www.ssa.gov/work/ResourcesToolkit/redbook_page.html

Ticket to Work

In depth information about the "Ticket to Work Program" for people with disabilities wanting to return to work.

http://www.socialsecurity.gov/work/Ticket/ticket_info.html

The Ticket to Work and Self-Sufficiency Program – "The Ticket" is a brief fact sheet put together by Protection and Advocacy, Inc (PAI)

<http://www.pai-ca.org/PUBS/542901.pdf>

This website is the official site of *Maximus*, the agency contracted by Social Security to administer the Ticket to Work Program. Provides information on individual Employment Networks and an overview of the Ticket program.

<http://www.yourtickettowork.org>

D. Service Coordination and Intensive Community Services

"I'm not a case; I don't have to be managed"

As the above quote suggests, the term case management has been tarnished by the sometimes heavy-handed, social control approach taken by some providers. Therefore, the use of the term "service coordination" is suggested.

Discussion of terms

The term "case management" was introduced into the public mental health sector in the early 1980's as part of the Federal Center for Mental Health Services, Community Support Program (CSP) initiative. Case management was promoted to address the lack of continuity of care and fragmentation of services in meeting the needs of persons with psychiatric disabilities.

Although lacking a uniform definition or philosophy, case management is generally considered to involve a single point of responsibility (individual or team), and assessment, planning, linkage, monitoring and advocacy in a relationship over time. This initial approach to case management was referred to as the brokerage model as the case manager is responsible for matching available resources with client needs.

The success of the brokerage approach to case management was hampered by the hiring of staff that did not have the knowledge or skills to work with persons with psychiatric disabilities. The identification of specific case-management skills and the integration of psychological principles into case-management practice led to the evolution of the strengths-based approach, intensive case management and assertive community treatment (ACT).

Designed as a package of services, assertive community treatment is characterized by more frequent client contact, provided by a multidisciplinary team with services delivered in the community rather than a clinician's office. Caseloads are low, shared by the team. Twenty-four hour availability, assertive outreach and an orientation to the teams providing as many services as possible as opposed to referring clients to other providers is characteristic of this approach.

The effectiveness of a comprehensive, one-stop shopping approach is one of the reasons that ACT is considered a best practice and is promoted by the Federal Substance Abuse and Mental Health Services Administration.

In California, ACT has evolved into Intensive Community Services or Integrated Services approaches. This approach continues to integrate all we know is helpful and expands on the traditional concept of a multidisciplinary team to include housing, employment, education and peer specialists.

Core Principles

Although ACT is considered a best practice, it should be noted that it is the principles, not the structure, that ensures a recovery-orientation to the service approach. In serving the goal of preventing hospitalization, ACT has been seen by some to over-emphasize medication compliance instead of addressing medication use in the context of serving client's goals. The following principles are considered key:

- Comprehensive (address all aspects of a person's life)
- Continuous
- Individualized
- Flexible
- Capable
- Meaningful (to the individual/family)
- Willing and accepting (to do what needs to be done)
- Culturally competent
- Resourceful (accessing all resources in a community)
- Participatory (doing with, not for) and
- Accessible (culturally, linguistically, physically, psychologically)

Intensity and Duration of Intensive Community Services

Two policy issues related to intensive community services need to be considered. They are limiting caseload size to ensure that services are intensive and providing intensive services to the same clients in perpetuity.

All of the major programmatic initiatives in recent years have included small caseload size and no time limits on services (e.g., AB 2034, SAMHSA Resource Manual for ACT, MHS Community Support Services Plan Requirements). However, recently published studies have suggested that providing more intensive services than needed or providing services longer than needed is inefficient and may even impede consumer recovery.

Sherman and Ryan (1998) noted that although small caseload size is often considered a determinant of the fidelity of intensive case management, the literature contains numerous examples in which there is no clear relationship between caseload size and the intensity of services provided. They also noted that consumers rarely require intensive services for extended periods.

As it has become clear that persons with serious mental illness can and do recover, fixing caseloads at low levels and providing intensive community services in perpetuity is often unnecessary. It has also been suggested that policies meant to ensure continuity of care may actually impede recovery by promoting dependency. "No consensus exists about whether 'in perpetuity' or 'lifelong' is the same as 'time unlimited.'" Time unlimited can be construed as lifelong. It may also mean that the duration of program involvement is individualized.

To maximize efficiency and effectiveness, service intensity should be based on individual consumers' functioning levels and desired goals. The Milestones of Recovery Scale described elsewhere in this primer is one such instrument.

Resource

Sherman, P.S., and Ryan, C.S., Intensity and Duration of Intensive Case Management Services, Psychiatric Services, December 1998 Vol. 49, No. 12

Surber, R.W., (Editor) Clinical Case Management: A guide to comprehensive treatment of serious mental illness, Sage: Thousand Oaks, CA 1994.

The SAMHSA resource kit on Assertive Community Treatment can be found at

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/>

E. Integrated Treatment for People with Co-Occurring Disorders

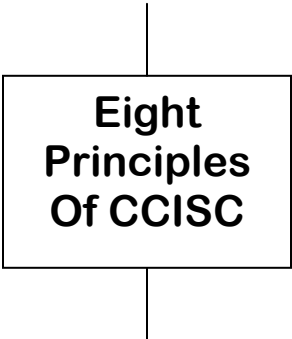
It is estimated that up to 10 million people in this country have a combination of at least one co-occurring mental health and substance-related disorder in any given year.

Individuals with co-occurring disorders tend to have multiple health and social problems and subsequently require costly care. Many are at increased risk of incarceration and homelessness.

Historically, there has been no single locus of responsibility for people with co-occurring disorders. Generally, mental health and substance abuse services operate independently of one another, each with its own treatment philosophies, administrative structures and funding mechanisms. Frequently, discordance between the two systems has created difficulties for consumers with co-occurring disorders from obtaining needed services in either system.

1. The Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services for individuals with co-occurring psychiatric and substance abuse disorders is designed to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states to regions or counties, networks of agencies, individual agencies or even programs within agencies. The model has the following four basic characteristics:

- System level change
- Efficient use of existing resources
- Incorporation of best practices
- Integrated treatment philosophy



Eight Principles Of CCISC

The eight research-driven and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. Dual diagnosis is an expectation, not an exception
2. Persons with co-occurring disorders are not all the same
3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting

4. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client and in each service setting
5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual primary diagnosis-specific treatment is recommended
6. Both mental illness and addiction can be treated within the philosophical framework of a “disease and recovery model” in which interventions are not only diagnosis-specific, but specific to phase of recovery and stage of change
7. There is no single corrective intervention for persons with co-occurring disorders
8. Clinical outcomes for persons with co-occurring disorders must also be individualized, based on similar parameters for individualizing treatment interventions

Action Steps. Implementation of the CCISC requires utilization of system change strategies in the context of an organized process of strategic planning. Ken Minkoff, MD and Christie Cline, MD describe a 12-step program for implementation of CCISC.

- Create a work group composed of persons from mental health and substance abuse including families and consumers to review the CCISC model for organizing services and make recommendations for implementation.
- Provide training for staff in Motivational Interviewing and harm reduction.

Example.

Community Research Foundation - San Diego, CA

<http://www.comresearch.org>

Several programs are on track to meet the criteria of “Dual Diagnosis Capability” as defined by Ken Minkoff, MD and Christie Cline, MD, creators of the CCISC model. These programs:

- Have staff who have received education and training in the principles of the CCISC model

- Have utilized a program evaluation to identify their level of Dual Diagnosis Capability
- Have developed Action Plans based on #2
- Are reviewing and revising Action Plans at 6 month intervals
- Are part of a systematic and ongoing process that addresses and makes changes at the clinical, program, and systems level
- Have a majority of staff at all levels trained on an ongoing basis in Motivational Interviewing

2. Integrated Dual Diagnosis Treatment (IDDT). The IDDT model is an evidence-based practice that improves the quality of life for people living with serious psychiatric disabilities and co-occurring substance use disorders. It provides fully integrated mental health and substance abuse treatment by the same providers, in the same place, at the same time. It utilizes treatments that address all aspects of a human being, and embraces wellness and recovery.

Research has shown that the IDDT model helps consumers achieve the best outcomes when services agencies maintain fidelity to the principles of the model.

Successful IDDT programs include the following service philosophies and strategies:

- Multidisciplinary Team – All activities of life are seen as part of the recovery process thus the team includes employment, housing, criminal justice specialists in addition to case managers, counselors, physicians, nurse and substance abuse specialists.
- Stage-Wise Interventions – Research suggests that individuals do best when they experience incremental successes through stages of change. The four stages are: engagement, persuasion, active treatment and relapse prevention.
- Access to comprehensive services – Included in the list of comprehensive services are: case management, integrated SA and MH counseling, medical services, housing, supported employment, family services and intensive case management.
- Time-Unlimited Services – Consumers with dual disorders may experience cycles of relapse and recovery throughout their lives.

Therefore, services are provided even when symptoms are mild and/or infrequent. In addition, this approach requires service agencies not to discharge consumers from treatment if they stop taking their medications or continue to use alcohol or other drugs. Setbacks may occur naturally as part of a lifelong cycle of relapse and recovery.

- Assertive Outreach
- Motivational Interviewing – Motivational interviewing provides techniques for service professionals to help consumers understand the relationship between what they want in life and what keeps them from achieving their goals.
- Substance Abuse Counseling – Clients who are in the active treatment or relapse prevention stage receive substance abuse counseling.
- Group Treatment
- Family Psychoeducation
- Participation in Alcohol & Drug Self-Help Groups
- Pharmacological Treatment
- Interventions to Promote Health
- Secondary Interventions for Non-Responders to Substance Abuse Treatment

Example

Bonita House – Berkeley, Ca

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

Bonita House is an excellent example of an integrated approach provided in a residential treatment setting. The Bonita House program was recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a leading provider of dual diagnosis services, and was chosen by the National Institutes of Health Center for Mental Health Studies/Center for Substance Abuse Treatment to produce a manual that is now used nationally by programs to develop their own dual diagnosis services. (www.Bonitahouse.org)

Resources

American Association of Community Psychiatrists presents the *Principles for the Care and Treatment of Persons with Co-Occurring Psychiatric and Substance Disorders*.

<http://www.comm.psych.pitt.edu/finds/dualdx.html>

Comprehensive, Continuous, and Integrated System of Care model (CCISC).

Dr. Minkoff presents a description and principles of this model for individuals who are dually diagnosed.

<http://www.kenminkoff.com/ccisc.html>

SAMHSA Toolkit available at

Co-Occurring Disorders: Integrated Dual Diagnosis Treatment

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/>

E. Peer Support Programs and Drop-In Centers

Empowerment happens when a person who is seen as the problem begins to see him or herself as part of the solution.

Saul Alinsky



According to Jean Campbell,²⁰ peer support programs vary greatly dependent on their members and the organizational history but the characteristics they have in common include creating a safe, supportive environment; an atmosphere of acceptance; learning from one another; and promoting self-worth, dignity and respect. Services also vary but include the following common elements “1) a focus on recovery and empowerment; 2) opportunities for members to tell their stories to other peers and to wider audiences; 3) belief that recovery is possible; and 4) the support of peers who believe in recovery.”

Recent reviews of the literature have identified evidence to support the effectiveness of peer-run support services in reducing social isolation, improving mental health, reducing symptoms, and enhancing communication with providers.

Peer support programs include mutual support groups, peer-run multi-service agencies, peer-run drop-in programs, and peer-run education and advocacy programs.

1. **Drop-in Centers.** Because of both disability and societal stigma, many mental health consumers are isolated in the community. They often lack the funds to participate in social and recreational activities. Many times, they lack confidence and social skills to develop the personal support networks that will ensure their survival in the community.

Opportunities. The consumer-run drop-in center provides multiple services to consumers on a number of levels. Homeless individuals and those new to the mental health system often use the centers as an entry point to services. The center offers some individuals a source of contact that provides an ongoing sense of community and support.

²⁰ Campbell, J. & Leaver, J. (2003). *Emerging new practices in organized peer support report*. Presented at NTAC's National Experts Meeting on Emerging New Practices in Organized Peer Support, Alexandria, VA"

Employment and volunteer activities are often available at the center and individuals can use these experiences as a springboard to full-time or part-time employment in the mental health system and beyond. Others may use the center as a form of respite or re-entry, attending only at times of great stress or need.

Fully developed (and adequately funded) centers can offer a myriad of services that really make them full-service community centers. These centers provide not only a sense of community, self-help, and socialization opportunities but also practical aid including: meals, emergency food, clothing, laundry facilities, emergency housing, transportation vouchers, education, and advocacy.

Along with providing a sense of community, voluntary daytime drop-in centers offer peer support and empathy that are recognized as powerful building blocks to recovery and wellness. Those centers strongest in providing positive role modeling are those with a high degree of consumer involvement and management.

The first tier and most empathetically powerful type of daytime drop-in centers are operated by non-profit agencies that are completely consumer run and managed. At these centers, participants see other consumers engaged in all aspects of running a business and social service agency, and the message that recovery is very strongly reverberates throughout the program.



A second type of drop-in center is the type which functions as an independent, consumer-run entity, but which may have some contractual relation with a larger non-profit organization. Even this type of center communicates strongly the idea that individuals can and do recover, earn a living and contribute to society.

Along with these two most desirable models, other models of the daytime drop-in center exist ranging from a blended model, to centers that have only token consumer involvement. Not surprisingly, the latter type of center is the least effective and inspires the least enthusiasm and trust from consumers.

Many consumers view drop-in centers (especially those of the first two varieties) as safe places where their concerns will be met with respect, dignity, understanding and caring. At the best of the day-centers, consumers view the programs as their own.

Action Steps.

Developing Drop-In Centers

- How can you increase the autonomy of your Drop-In Center
 - Do consumers make all decisions and have a sense of ownership of the Center
 - Should the hours of operation be adjusted to meet the needs and schedules of both members and consumer staff
 - What Peer Run services are available
 - Peer Counseling
 - Support Groups
 - Warm Lines
 - Buddy system
- 
- 
- Meals
 - Emergency Food baskets
 - Vocational services
 - Pre-Vocational Training
 - Clothing
 - Tender Loving Care²¹ – In-Home Support Services
 - Community Projects
 - Recreational Outings

²¹ TLC is a program where consumers assist fellow consumers with household or other tasks in central Contra Costa County.

- How often are these services offered?
- Does the MH system tell consumers about self-help programs and services?

Examples.

Berkeley Drop-In Center – Berkeley (Alameda County)

http://banmhc.org/directory/ala_berkeleydropin.html

The earliest consumer-run Drop-In Center in California and is part of the consumer-run Alameda Network of Mental Health Clients.

Mental Health Consumer Concerns – Contra Costa County

(925) 646-5788

MHCC is the second oldest consumer-run organization in the nation. The agency provides patients' rights advocacy in Contra Costa, Napa and Solano Counties and operates four drop-In type community centers.

Interlink – Santa Rosa (Sonoma County)

<http://www.interlinkselfhelpcenter.org>

Consumer-run drop-In Center located in Santa Rosa that operates with Goodwill as their fiduciary agent.

Project Return: The Next Step – Los Angeles County

<http://www.mhala.org/project-return.htm>

Operated through the Mental Health Association of Los Angeles, Project Return offers Self-Help Clubs, a Warm Line called the Friendship Line, community activities, discovery centers, employment, advocacy and Japanese consumer exchange.

Consumers Self-Help – Sacramento

<http://www.consumerselfhelp.org>

Consumers Self-Help is an independent non-profit drop-in center founded in 1986. CSH consists of two day-time multi-service centers and operates the Sacramento County Office of Patient Rights.

G. Peer-Run Training. One of the necessary ingredients of recovery is the instilling of hope. All too frequently, consumers have been stymied in their attempts to achieve wellness and recovery: erroneously convinced that their destiny is a lifetime of living on disability benefits.

Opportunities. Consumer-run pre-vocational programs, often developed and led by consumers, provide skills training in peer counseling, helping skills, self-care and navigating the system in a classroom setting. By featuring consumer trainers whenever possible, the students are presented with a variety of positive role models.

Ideally, the classroom training is followed by an internship or work-study position at an agency or program that provides practical work experience and in some cases, may lead to a permanent job. While offering an opportunity for consumers to explore careers in mental health, these internships increase the visibility of consumers as employees in the mental health workplace. Perhaps most importantly, these trainings assist the consumer in making the role transformation from a recipient of services to a provider of services.

Action Steps

- **Identify or development your own curriculum**

Review existing training curriculum and/or brainstorm the topics your training is to cover. Consider including a minimum of:

- Peer Counseling skills
- Helping skills
- The role of the helper
- Navigating the system
- Confidentiality
- Creating your own WRAP (Wellness Recovery Action Plan)
- Recovery principles and ethics.

*"A Diagnosis
Is not
A Destiny"
Betty
Dahlquist*

Other topic areas may include:

- Dual Recovery
- Crisis Intervention
- Financial Benefits and Work
- ADA rights
- HIV
- Charting and record keeping
- Facilitating groups
- How to help Suicidal Persons
- Violence de-escalation
- Medications
- Patients' Rights
- How to make referrals
- Cultural competence
- History of the Self Help movement
- Interviewing skills
- Resume writing

- **Identify Trainers with Needed Expertise**

- Consumers knowledgeable in self-help and/or particular skill areas
- Crisis/Suicide Hotline trainers or trainers from other programs that train paraprofessionals
- Peer counselors available to provide peer support to individual students

- **Identify site to have training**

Often it is preferred to have the training at a non-mental health setting to validate the students' independence from the role of service recipients

- **Outreach** to consumers currently in treatment to participate in the training

- Develop outreach flyer to be sent to programs
- Arrange to visit mental health programs to recruit participants. (This may involve first meeting with staff to describe your program)
- Maintain an interest list of those interested in taking a future training

- **Meet with professionals to develop internship/work-study positions**
 - Develop internship job descriptions – how many hours a week, skills utilized, is client contact required
 - Does the system have entry level mental health positions that may be filled by your trained consumers
 - Will staff at the internship sites need training to welcome and support consumer interns
- **Funding**
 - Are you able to offer stipends or hourly wages for internships
 - Identify employment/stipend paperwork for interns
- **Agreements**
 - Develop a standard of conduct that interns sign before beginning their internship
 - Develop written agreements or Memoranda of Understanding (MOUs) between internship sites and the training program
- **Supports for interns**
 - Weekly support and supervision groups
 - individual support when difficulties arise on site
- **Evaluation**

Consider developing evaluation forms to solicit feedback from:

- Students regarding the classroom trainers, training topics, the internship experience
- Agencies and programs about the internships in general
- Internship supervisors' evaluation of students
- Instructors, evaluating students' overall performance

- **Graduation**

Celebrate! – A ceremony validates the students' accomplishments



Examples.

SPIRIT²² Training program is a joint project of Mental Health Consumer Concerns and the Office for Consumer Empowerment in Contra Costa County. SPIRIT training provides training, internship opportunities and peer support.

BEST Now! in Alameda County is similar to SPIRIT in offering training and internship opportunities as well as ongoing peer support.

California Network of Mental Health Clients produced a Peer Counseling Training video that briefly demonstrates basic skills.

H. Tools for Self-Help and Personal Responsibility

1. **Wellness Recovery Action Plans (WRAP)**²³. Consumers often have difficulty with recurring issues and feelings that may interfere with obtaining and keeping employment, success in school, or simply enjoying life.

Opportunities. WRAP support groups can be offered through peer-run self-help centers and other peer-run programs.

“Developed by mental health consumers who were struggling to incorporate wellness tools and strategies into their lives, WRAP is a self-management and recovery system designed to:

- Decrease and prevent intrusive or troubling feelings and behaviors
- Increase personal empowerment
- Improve quality of life
- Assist people in achieving their own life goals and dreams.

WRAP is a structured system to monitor uncomfortable and distressing symptoms that can help consumers reduce, modify or eliminate those symptoms by using planned responses. This includes plans for how the consumer wants others to respond when symptoms have made it impossible for them to continue to make decisions, take care of themselves or keep themselves safe.

With the assistance and support of a WRAP support group, the person who experiences symptoms develops their personal WRAP. The person may choose to have health care professionals help them create their WRAP.²³

Action Steps.

- Identify a consumer group that will sponsor WRAP support groups

²³

Mary Ellen Copeland has developed books and training resources that can aid in the development of WRAP support groups. See <http://www.mentalhealthrecovery.com>

- Locate funding to purchase WRAP books and training materials and for consumer coordinator/trainers to attend WRAP training at the Copeland Center
- Hire consumer coordinator/trainer to develop WRAP facilitator training for local consumer facilitators
- From graduates, identify support group facilitators. It is suggested that groups be co-led so that the group can continue when one facilitator is unavailable
- Identify locations, dates, and times for holding WRAP support groups
- Advertise support groups
- Support group facilitators keep contact information for members and may provide peer support outside of meetings to deal with feelings that arise from looking at and talking about symptoms. Facilitators also keep track of statistics for funding purposes
- Consumer coordinator/trainer provides training and supervision to facilitators, which would include a monthly facilitator support group.

A word of caution: The motivation and drive for creating and implementing a WRAP plan comes from the consumer. Attempts to require WRAP as a condition of employment or as part of a treatment plan ultimately run counter to the empowerment and spirit of WRAP.

Examples.

Recovery Specialist Project, a part of the consumer run Mental Health Consumer Concerns offers WRAP support groups at 3 consumer-run community centers in Contra Costa County as well as on-site at several mental health programs.

PEERS (Peers Envisioning and Engaging in Recovery Services) offers one day orientations to WRAP and an annual two-day training for WRAP support group facilitators in addition to support groups throughout Alameda County.

2. Psychiatric Advance Directives

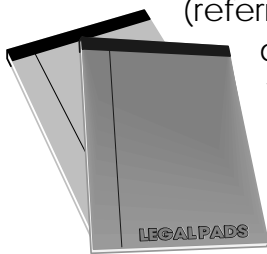
Positive changes have been occurring in the public mental health system throughout the country. Many of these changes are related to a philosophy of providing care that empowers consumers to be active participants in their treatment and to fully participate in the planning and operation of the public mental health system.

However, even in those places where staff is committed to empowering consumers in the planning and the execution of care plans, the entire process of cooperation breaks down and becomes unilaterally professional at the time when involuntary care is required. This *reversion* to a situation where consumers are stripped of power to make many of the choices about the kind of care they receive is especially ironic at the point where the client is about to experience the most intensive treatment the system offers.

Consumers live in fear of the involuntary commitment process as it represents the epitome of a total loss of control over what will transpire. Providers are uncomfortable with the bureaucratic, legalistic maze, which surrounds the involuntary treatment process. Some believe that this needs to remain the case because the law is structured to require someone other than the recipient to direct the care to be given. There are alternatives.

Recent changes in legislation in many States give individuals the right to specify, in advance, choices about how they will be treated in the event that their circumstances renders them incapable of exercising choice. The mechanisms for indicating choice are forms of "advance directives." Advance Directives (ADs) involve the creation of legal documents during a time when the "illness" is not severe enough to impair judgment.

The documents can: 1) specify consumer choices for treatment parameters (referred to as "instruction directives"), and/or 2) designate a durable power of attorney for medical decisions – a proxy – who is legally authorized to make choices on behalf of a person who has impaired decisional capacity (referred to as a "proxy directive"). The enactment of AD statutes present an exciting opportunity to extend power to individuals with serious mental illness in the domain of involuntary psychiatric treatment as persons who are involuntarily committed may lack decisional capacity for medical treatment.



Initial reactions from members of the judiciary indicate that the presence of an advance directive for psychiatric care would be perceived as very

helpful in enabling judges to meaningfully comply with unified substituted judgment standards that require judges to choose what the client/patient would have chosen.

Additionally, Advanced Directives offer the opportunity to improve the process of care from the perspective of the treating physician. A physician is often faced with a range of acceptable treatment choices. Without advance directives, the treatment preferences of a client presenting in crisis are unlikely to be known to the physician. The physician must then fall back on personal biases, chance, or some other non-specific mode of soliciting and weighting alternatives. ADs offer the means of providing the physician with important information about the patient's preferences so the physician can choose to factor these into his/her decision-making process.

The person's rationale for why they are expressing the preferences would also be included. The rationale would speak to the patient's perceptions of the risks and benefits of (including prior positive and negative reactions to) particular interventions and parameters of treatment. Such information would be of great value to persons charged with treatment responsibilities for people unable to provide such information.

Extensive discussions with consumers have resulted in the identification of the following content areas to be considered for coverage in the ADs documents:

- Specific treatments that have and have not worked in the past
- Who is to be notified that involuntary commitment has occurred
- Who is to be allowed to visit the consumer in the hospital
- Consents to contact previous care providers
- Consumer preferences for particular pharmacological treatment regimens along with rationale for choice
- Consumer preferences regarding electroconvulsive therapy (ECT)
- Consumer preferences about how to handle "emergency forced treatment" (i.e., medication versus seclusion versus restraints)
- Consumers' instructions about what should be done about child care (temporary custody) for their children during the commitment

- Consumer preferences for “types of activity therapy”
- Consumer desires about which hospital and physician they would prefer
- Consumer preferences for community-based round-the-clock acute care alternatives to hospitalization
- Consumer preferences regarding lengths-of-stay in combination with preferences for type of residential arrangements at discharge (e.g., shorter hospitalization followed by discharge to a more intensive aftercare unit (if available), versus longer hospital length-of-stay in combination with a discharge back to the pre-crisis residence)
- Consumer preferences for typical and customary treatments (non-experimental) that have not been tried previously for this consumer’s condition
- Consumer’s willingness to be approached for consent to participate in informal/formal experimental studies while hospitalized
- Experiential anecdotes about what occurred during past hospitalizations that the consumer perceived as beneficial and what might have been the “trip wires” that set off negative reactions
- Preferences for aspects of medical care (i.e., life sustaining treatments “do not resuscitate orders, organ donation, etc.)

In summary, ADs present a wonderful opportunity to: 1) enable mental health consumers to influence involuntary psychiatric care; 2) provide important information to guide physicians in making difficult treatment decisions; 3) ease the burden of judges attempting to guess what a consumer would prefer; and 4) simultaneously reduce the length of commitment and costs associated with involuntary care.

3. Housing Advance Directives

The California Network of Mental Health Clients has developed a format a Housing Advance Directive. A Housing Advance Directive can help protect the family, pets, housing and personal property when a consumer is involuntarily hospitalized.

Resources

The *Bazelon Center for Mental Health Law* presents answers to frequently asked questions about psychiatric advance directives and forms that can be used to create an Advance Directives.

<http://www.bazelon.org/issues/advancedirectives/faq.htm>

Making Advance Directives Work for You by Daniel Fisher, M.D on the National Empowerment Center website.

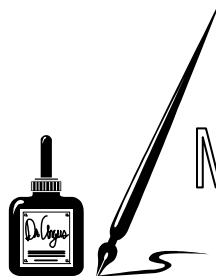
http://www.power2u.org/selfhep/directives_work.html

Advance Directives Are What You Make Them by Xenia Williams on the National Empowerment center website.

<http://www.power2u.org/selfhep/directives.html>

Power of Attorney: Housing Advance Directive (2004). Published by the California Network of Mental Health Clients, 1772 J Street, Suite 324 Sacramento, CA 95814. (800) 626-7447 email: main@californiaclients.org

Srebnik, D. S., Rutherford, L. T., Peto, T., Russo, J., Zick, E., Jaffe, C., & Holtzheimer, P. (2005) The content and clinical utility of psychiatric advance directives. *Psychiatric Services*. 56(5), 592-598.



Make Your Needs Known

4. Reclaiming Power During Medication Appointments

All too often, medication appointments with prescribing physicians are a very disempowering experience. Consumers may be expected to go along with the decisions of the doctor, without the opportunity to be fully informed. Patricia Deegan, Ph.D., has developed five strategies to help consumers when meeting with psychiatrists.

Strategy #1: Learn to think differently about medication

Medications are only a tool and not the cure for the symptoms of mental illness. Other tools include non-institutionalized treatments such as exercise, eating well, avoiding alcohol and street drugs, love, solitude, art, nature, spirituality, work, and many other coping strategies that work for individuals. All of these tools may be equally important to one's recovery.

Choosing to take medications is an individual choice and is not a sign of weakness. Some consumers may decide not to take medications while others may choose to use them only for acute episodes in which they find other coping strategies ineffective. What matters is taking care of oneself in such a way as to be the best person you can be. Taking medications is a person choice.

Always use medications and coping strategies. Many non-drug coping strategies can help alleviate symptoms and distress. Learning to use a variety of non-drug coping strategies helps to minimize the amount of medications required, or, with practice, actually eliminate the need for medications.

**Five
Important
Strategies**

Knowledge of the medications an individual is taking can be very empowering. Many sources of information exist that can provide information at varying levels of technicality. A fact sheet of basic understanding of a medication, its intended effects and possible side effects can be obtained from your local pharmacist. This information gives a basic overview in terms the layperson can understand.

Some clients may desire more in depth knowledge of the medications they are taking or considering taking. The pharmacist can provide the drug-inserts provided by the pharmaceutical company. These inserts contain essentially the same information as the Physicians Desk Reference (PDR), the book that doctors rely on for medication information.

There are many other resources available at the library and on the internet that serve a number of purposes. There are dictionaries of medical terms, web sites with both basic and in depth information on the individual medications, and books with varying opinions on the subject of psychiatric medications. Some books may integrate information on medications and self-help techniques. In addition, do not forget, talking other consumers who have taken various medications can provide first hand accounts of their experiences whether they are positive or negative.

Armed with the knowledge available, the consumer can feel more confident in having a thoughtful and productive discussion with their psychiatrist.

Strategy #2: Learn to think differently about yourself

Consumers know themselves better than any mental health professional. The very person prescribing the medications dismisses too often consumers who are experiencing uncomfortable side effects. They are told that “it is all in your head” and that what they are feeling, thinking, or perceiving was not really true.

Pat Deegan points out that this journey is the consumers’ journey and does not belong to anyone else. She goes on to state:

Too often, I have heard people say, “the drug made me feel better.” Do not give all the credit to the chemical! Even if you found a drug helpful, look at all the things you have done to get well and stay well. A drug can sometimes open a door, but it takes a courageous human being to step through that door and build a new life.

Medications can alleviate enough of the symptoms to allow the consumer to engage other coping strategies and continue on a positive journey of recovery.

Consumers’ questions are important and should be answered. Consumers who have been on medications for a while may ask some tough questions such as:

- What am I really like when I am off these medications?
- What is the “real me” like now?
- Is it worth taking these medications?

- Are there non-drug methods I can learn to reduce my symptoms instead of using medications?
- Have my needs for medications changed over time?
- Do I have tardive dyskinesia that is being masked by the neuroleptics I am taking?
- There are not-long term studies on the medication I use. Am I at risk? Do I want to take the risk of not knowing the long-term effects?
- Am I addicted to these medications?
- Has long-term use of these medications resulted in memory loss or decreased my cognitive functioning?

All of these are valid questions that should be discussed in a non-confrontational or denigrating manner. Consumers have the right to determine what risks they are willing to take and to question the efficacy of these medications over the long term.

Strategy #3: Think differently about psychiatrists

In this age of managed care, psychiatrists are being asked to see more clients in less time. This translates to inadequate time to read a person's treatment history. Without this historical knowledge, they may prescribe medications that have already been tried and failed or even inappropriate medications given a person past experiences. Ms. Deegan suggests that consumers keep their "own record of what medications have been tried, for what symptoms, at what dosages, and for what period of time." When a new medication is being discussed, the client has the information readily available of their past medication experiences.

Psychiatrists may have conflicting interests. Often this is the influence of managed care companies who require that one type of drug be prescribed over another. Sometimes they are working for a managed care company that places caps on services. Exceeding these caps may negatively affect the psychiatrist. Consumers should know about these competing interests and be able to discern when their doctor is being influenced to prescribe a particular medication.

As with any other doctor, psychiatrists are sometimes wrong. When surgery is considered for a medical condition, a second opinion is often sought. In mental health, second opinions regarding diagnosis and treatments are not

encouraged. Despite constraints of managed care plans or Medicare and Medicaid, second opinions can be sought. Often this requires a lot of work and advocacy but can be worth it given the stakes.

Strategy #4: Prepare to meet with your psychiatrist

Psychiatrists most often are working with very limited time to see each client. Being prepared and setting out the agenda helps to put the consumer in the driver's seat. A meeting preparation guide is available through the National Empowerment Center.

Being specific gives the doctor more information and allows the psychiatrist to become a co-investigator as opposed to an authority. Being able to provide specifics may require such tactics as using mood charts, recording medication and/or self help trials on a daily basis, summarizing the experiences since the last meeting, and other strategies to be able to summarize what has happened since the last appointment. Using such tools also allows the consumer to write a summary before seeing their psychiatrist and setting their agenda for the appointment.

Probably the most important aspect of a medication appointment is asking questions. Consumers should write them down. It is easy to forget as the appointment becomes stressful and miss out on important information. If a consumer is considering trying a new medication, they should ask the following:

- Exactly how will I know if this medication is working for me?



- How long before I should start to notice an effect from this medication?
- What are the unwanted effects or side effects associated with this drug?
- If I should experience unwanted side effects, what should I do about it?
- How can I contact you if, during this medication trial, I have questions and concerns I want to check out with you?

The information that can be obtained from pharmacists and other sources should be augmented by the answers the psychiatrist provides.

A final tool to help prepare for the meeting is to role-play various scenarios. Learning to talk to a psychiatrist from the position of personal power is a skill that can be learned and must be practice.

Strategy #5: Take charge of the meeting

The medication appointment is one of the most important engagements with a mental health provider. After time is put in preparing for the meeting, the next step is to set an agenda. At the beginning of the appointment, the consumer can set the tone and direction of the meeting by stating the agenda aloud. Resistance from the doctor can be expected in most circumstances, as psychiatrists are accustomed to doing the talking and observing. With practice, a relationship can develop where the power is not automatically on the side of the psychiatrist.

Consumers should consider taking a note pad and pen to the meeting. Often people cannot absorb and remember all that is discussed in a meeting with any doctor. Jotting down notes during a medication appointment allows the consumer to go back and refresh important points such as adverse effects to watch out for or changes in dosing when starting or stopping medications.

Another tool consumers can use to capture the information is to take a tape recorder. Some psychiatrists may be uncomfortable with this tactic but a brief explanation of the reason why they wish to use the recorder may help to ease some of the reservations. Asking for permission first shows respect for the psychiatrist and may help preserve the relationship in a positive manner.

Finally, taking a friend or support person can help, especially at first. Two ears are always better than one and a second person in the meeting can help to capture information that may get lost once the meeting is over.

Conclusion

These are just a few strategies that can be used in medication meetings with the psychiatrist. Every individual learns differently and may find some of these ideas more helpful than others. Some may develop other strategies that better help to facilitate and direct their recovery. "What is important is to realize that you can take your power back and become the director of your own recovery and healing," states Deegan.

Resources

The *National Empowerment Center* provides a free information packet with a guide to preparing and organizing your own medication/self-help trial and a sample meeting statement can be obtained by calling the National Empowerment Center at (800) POWER2U. Or visit www.power2u.org.



Deegan, Pat Ph.D., "Reclaiming your power during medication appointments with your psychiatrist" can be found on the website of the National Empowerment Center
<http://www.power2u.org/articles/selfhelp/reclaim.html>

I. Wellness Recovery Center

The Stanislaus County Wellness Recovery Center (WRC) employs consumer and professional staff and has a viable volunteer program made up of people in recovery from mental illness. Peer staff and volunteers provide individual supports and an array of group supports. They also provide outreach to their 'peers' in psychiatric hospitals, residential facilities, facilitate mutual-aid groups, and provide transition supports for people returning to the community after hospitalization or experiencing other life changes. These supports are outside of the clinical realm, are not documented or billed services, and are open to all WRC clients, other mental health clients, as well as any individual diagnosed with a mental illness. All volunteers receive ongoing support, education, and supervision (individual and in group settings). WRC peer staff and volunteers do not volunteer or work where they receive services, although they may receive care elsewhere.

WRC professional staff provides medication services individually and in-group settings for about 300 open clients. WRC has a limited capacity (one professional staff person for up to 300 clients) for brief episodes of client-coordinated care, sometimes referred to as "case management." Individuals are referred to the WRC from more intensive outpatient programs. They have either completed their services there (which is preferred), or they have established long-standing stability and no longer require the intensity at the higher level of care (less preferred). Over time those who require or request more intensive kinds of services (either more frequent contacts or greater diversity of service), are referred to a multidisciplinary outpatient regional team. Many of these individuals return to WRC once this need for more service has been met. Unlike peer supports, medication and coordination of care services are billable and documented as part of a person's mental health care.

J. Health Maintenance Services

Individuals with severe and persistent mental illness have higher morbidity and mortality rates than the general population. This is a result of factors directly related to their illness such as side effects of medication including diabetes and obesity, factors related to life style – homelessness, substance abuse, smoking, and difficulty accessing preventive care.

Opportunities. When an individual enters a mental health program, an evaluation of their physical health and wellness needs to be part of the initial assessment. This evaluation should include a physical exam, review of all medication and medication side effects, a medical history, formulation of a problem list, development of a health maintenance plan, and identification of health providers.



A Health Maintenance Plan should include a schedule of routine physical exams including vision and dental and routine tests including pap tests, mammograms, rectal exams, cholesterol screening, TB test, as well as any tests related to specific conditions or lifestyle issues. The plan should identify risk factors such as smoking, alcohol and/or drug use, homelessness, and obesity. It may also address wellness issues such as diet, exercise, and stress management.

Coordination of care is critical. Contact should be made with the primary medical provider at both admission and discharge. Coordination between the psychiatrist and medical doctor is vital to assure there are no negative drug interactions.

There are two models that could be replicated to provide healthcare to consumers in community mental health programs:

- Become a satellite clinic to a Federal Qualified Health Center (FQHC). A mental health agency or program can negotiate with the FQHC to provide basic health care at their site by becoming a satellite clinic. Typically, this will mean provision of basic services by a family nurse practitioner, lab services, and referral to the main clinic for specialized services.
- Develop an agreement with a nursing program to provide basic health services on site by both nurse practitioners and rotating nursing students.

Action Steps.

- Develop affiliations with nursing programs and/or FQHCs.
- Provide training for staff in evaluating physical health and wellness needs and developing a health maintenance plan.

Examples.

Bonita House - Berkeley, CA

<http://www.bonitahouse.org>

Bonita House serves as a satellite clinic to Lifelong Medical Care, a FQHC in Alameda County. A family nurse practitioner provides medical services to Bonita House clients 1 day per week. A lab picks up urine and blood samples daily. Clients who need specialized medical care are referred to the main health center. 60% of Bonita House clients receive their health services from the satellite clinic.

Progress Foundation – San Francisco, Ca

<http://www.progressfoundation.org>

Progress Foundation has negotiated an agreement with UCSF School of Nursing. Nurse practitioners provide basic medical services on site to Progress Foundation clients. In addition, nursing students have a rotation through Progress programs.

K. Community Residential Treatment Alternatives

"What are the implications of a recovery philosophy and practice for patterns of institutionalization in a county service system (i.e. inpatient, IMD, Board and Care)?"

Steve Fields – Progress Foundation



In the federal Olmstead decision, the Supreme Court ruled that persons with disabilities are entitled to receive whatever services and/or supports enable them to live in the community and avoid institutionalization. This includes a right to services that prevent institutionalization as well as assistance to acquire the skills and supports necessary to live successfully in the community for those currently institutionalized.

Through the development of residential treatment alternatives, Counties can reduce the use of institutional settings. This includes reducing involuntary care in acute care settings such as that provided in public and private hospitals and psychiatric health facilities and long-term care provided in state hospitals, skilled nursing facilities and mental health rehabilitation centers.

Purpose of Residential Treatment Programs. Residential treatment programs provide structured and intensive services in a residential setting to individuals who would otherwise be in a 24-hour institutional setting. Residential treatment services are not housing resources. Treatment services are offered in a residential setting, and this often creates the impression that the programs are a form of housing. The purpose of residential treatment programs within a system of mental health care is twofold:

- To provide treatment alternatives for those individuals who would otherwise be admitted to, or remain in, acute and long-term hospitals or other institutional settings, including jails, due to the severity and seriousness of their disabilities; and
- To utilize a range of residential settings to move the mental health system from an institutional dependency to a community-based services capacity.

Permanent, affordable housing with necessary support services and vocational opportunities should be the basic building blocks of a community mental health system. However, for those individuals who require or request more structured settings, a range of residential treatment alternatives to various levels of institutional or custodial care should be developed in order

to assure that a system of care utilizes institutional beds only when it is absolutely necessary.

.....
• *No person with a mental illness should have to be treated or held in a*
• *hospital psychiatric unit, state hospital, jail cell or skilled nursing*
• *facility simply because the individual requires intensive support and*
• *there are no available levels of service between supported housing*
• *and institutional care.*
.....

Systems that repeatedly attempt to make the leap from institutional setting to permanent housing (with a package of support services) often find that transitional approaches are required.

Overtime, the number of individuals who are successfully living in housing of their choice and who rarely require more intensive settings for temporary treatment, demonstrate the success of such strategies. Thus as systems attempt to break the cycle of repeated admissions to emergency rooms and hospitals, these alternative 24-hour settings change the patterns of utilization within communities.

Residential treatment programs are often misunderstood and misused resources in community-based systems of care. These settings may be used exclusively for long-term housing, serving individuals who could and should be living independently in the community. Other residential programs are expected to provide an entire range of services, from crisis intervention to long-term treatment, in one facility, creating contradictory demands on staff and program participants.

Another common misconception is that a continuum of residential treatment resources represents a mandatory linear progression through which each individual must progress toward more independent living.

In fact, the continuum of services represents an array of options, not a mandatory set of required steps. The referring person, the individual with mental illness, family members and the system *gatekeepers* must match the level of service to individual need and moves should be designed to minimize unnecessary transitions from one program to another.

1. **Crisis Residential Treatment.** Twenty-years ago, the prevailing mentality was that crisis treatment could only be accomplished in a hospital environment. We now know that crisis stabilization, including drug response, can best be provided in a community-based setting. Community-based, home-like crisis residential treatment settings are more effective and far less

expensive than hospital settings for acute psychiatric care. Evidence shows that crisis residential treatment is clinically comparable to hospital treatment for many clients at one-third to one-half the cost of hospitalization.

The first crisis residential treatment program opened in California in the mid-70s. Although there was much skepticism and resistance to the idea originally, when the program demonstrated its willingness and ability to divert acute clients from high-cost hospitalization, the county mental health authorities funded an expansion of crisis residential treatment programs. Today, the acute residential treatment programs should be an indispensable level of care within a system that is always facing escalating mental health costs.

**Community-
based
settings
work best**

To be most effective, a crisis residential treatment program should be a part of a larger crisis response system (Stroul, 1987). The crisis program should exist within a crisis response system that includes the following critical elements:

- 24-hour- a- day, 7 day- a- week available walk-in emergency services
 - Mobile crisis and outreach capability
 - Short-term (up to two weeks) case management for individuals who are referred to 24-hour treatment settings
 - Inpatient services linked to community resources
 - Centralized and coordinated triage to authorize hospitalizations

Resources

Crisis Residential Toolkit, by Steve Fields can be obtained by contacting Progress Foundation, 368 Fell Street San Francisco, Ca. 94102. Phone (415) 861-0828 or email SFields@Progressfoundation.org.

Community Research Foundation, San Diego, CA
<http://www.comresearch.org>

Progress Foundation, San Francisco, Napa, Sonoma
<https://www.progressfoundation.org>

2. Transitional Residential Treatment. Transitional Residential Treatment Programs provide a sub-acute level of care as an alternative to psychiatric skilled nursing settings, state hospitals and as a rehabilitation-oriented alternative to board and care.

The success of the community mental health treatment system depends upon the availability of transitional residential treatment services. Without such services, clients cycle through brief acute treatment without addressing the rehabilitation and community support needs that must be met if they are to move toward independent living.

In addition, clients may in the acute sector longer than necessary if they do not have a fully staffed, structured residential treatment resource that can continue the treatment plan started in an acute phase. Transitional programs, therefore, serve individuals who are at the risk of returning to the hospital if this level of structured living were not available.

Transitional programs are housed in large family homes in residential neighborhoods. The facilities blend in with other homes, and are not outwardly identified as mental health programs. Clients can obtain treatment, successfully work through most crisis situations should they occur, and experience supported community living without the stigma and trauma of an institutional placement.

The target length of stay in transitional residential programs varies from three months to one year depending on the target population.

Staff develops supportive and trusting relationships with clients. The staff provides counseling, support, and assistance to clients, and links them with other services and providers they might need to use in order to return to living in the community. Staff assesses vocational readiness and provides pre-vocational counseling, referrals, and placement upon client request.

Clients and staff work together to operate the household. The expectation is that each client fully participates in the group living experience, including meal planning and preparation and keeping the house clean. Clients are encouraged to take responsibility for planning their own treatment and for participating in group activities. Treatment plans, which are goal-oriented and time-limited, are reviewed weekly with staff.

Many who enter the program lack the skills necessary for independent or semi-independent living. Staff works with these clients on a very basic level -- on such issues as personal hygiene, money management, and cooking. It is

central to the philosophy of the program model that more tangible and therapeutic gains are made around the planning and preparation of a meal, for example, than around more formal, traditional therapy interventions.

The program offers a day and evening structure, consisting of group therapy meetings, socialization and physical activity sessions, and a range of skill-building workshops. Overall, staff works with clients to explore healthy, positive ways of living and reacting to difficult life situations.

California has led the nation in the development of residential treatment alternatives that are designed to meet the treatment needs of those with co-occurring mental health and substance abuse disorders, women with children and older adults. What follows is a brief description of these programs.

Dual Diagnosis Adult Residential Treatment. Transitional residential treatment programs are particularly effective in assisting persons who have active drug or alcohol abuse issues, co-occurring with major mental health needs. Dually diagnosed individuals require a high degree of structure and support, particularly in the early intervention stages of treatment. This intervention can be done more effectively in a residential setting than in a hospital or other institutional setting.

Programs strive to build a sense of community, dignity, and hope for people recovering from both psychiatric and substance use disorders. Recovery from dual diagnosis is seen as a long process. From admission to the residential treatment program and beyond discharge, clients are taught to expect intensive and coordinated services that will be made available as long as they need them. Clients are given the message that they "need never go it alone."

Example.

Bonita House located in Berkeley, California is an excellent example of a Dual Diagnosis Residential Treatment Program. Recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a leading provider of dual diagnosis services, it was also chosen by the National Institutes of Health Center for Mental Health Studies/Center for Substance Abuse Treatment to produce a manual that is now used nationally by programs to develop their own dual diagnosis services.

Bonita House's conceptual framework incorporates principles of psychosocial rehabilitation within an integrated treatment model. Treatment is individualized, and is designed to address each client's mental illness and

substance use. Many people come to the program from locked, involuntary settings such as psychiatric hospitals. As a result, they have lost control of, and responsibility for, their lives over time. The treatment approach seeks to re-empower program residents and to enhance their sense of trust through the formation of strong client-provider relationships.

Residential program staff represents a multi-disciplinary team of professionals, paraprofessionals, interns, and volunteers who have been chosen for their abilities to engage this diverse and challenging population in treatment.

While clients come with various needs, certain needs are common among the dually diagnosed. These include:

- Psychiatric symptoms and medication management
- Recovery and abstinence from substance use
- Decision-making and independent living skills training
- Pre-vocational and vocational training
- HIV/STD education
- Health and nutrition education
- Advocacy
- Housing

The maximum length of time that a client can stay is 12 months; most residents stay in the program for about 6 months. Clients who leave prior to completion of treatment, about 30%, do so because they have either violated resident house rules, are incarcerated, have developed a need during treatment that the program cannot meet (e.g., physical health care), or have left against staff advice. Clients who complete the program are typically discharged to a clean and sober living environment, or other housing within a “harm reduction” community.²⁴

²⁴ There is no generally accepted definition of “harm reduction.” However, the International Harm Reduction Association (IHRA) recommends that the term should be understood to mean, “...policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and their communities.” (<http://www.ihra.net>)

It is important that the program view recovery from dual diagnosis as a long-term process. Each client needs to receive the message early in treatment that s/he does not have to face recovery alone, and that support and services are available as long as they are desired and needed. When the program is linked to supportive independent living (SIL) programs, this approach can be best fortified through the introduction of SIL case management services early in the treatment process, and the promotion of a cooperative relationship between residential treatment program counselors and case managers in addressing the client's needs.

Programs for Women with Children, One of the tragedies of mental illness is the disruption in the relationship between parents and their children. Women seeking treatment are often faced with the reality of losing custody of their children. Ashbury House, established in 1995, is an example of the application of a transitional residential treatment approach to serve women and their children.

Ashbury House serves 8 -10 mothers and their children with a maximum capacity of 20 individuals. The program, located in the Haight-Ashbury district of San Francisco, provides 24-hour treatment, rehabilitation and parent education. The program serves homeless women who are at risk of losing custody of their children because of their mental disability, as well as women who have already lost their children due to their disability and who now need comprehensive mental health services and parent education in order to regain custody. Licensing requirements limit the program to allowing a maximum of two children per mother.

Ashbury House is designed to help each family develop the skills and the support system needed in order to live independently in the community. A flexible day treatment program provides counseling and structured activities. These include individual counseling and group therapy, substance abuse education and treatment, parent education, pediatric and women's health education, pre-vocational assessment and preparation, recreation, and skill building.

Parenting Education

Education regarding each client's mental disability, its effect on parenting, and strategies to avoid negative consequences to her children is an integral part of the program. Other services include advocacy and service brokerage for mothers and children spanning mental health services for adults and children, substance abuse services, vocational programming, parenting classes, adult education, and training programs.

Counselors assist mothers as they work with the San Francisco Unified School District in accessing appropriate assessments and services for the children. Nurse Practitioners are available every other week to attend to a client's medical needs that often have gone undetected and untreated for long periods.

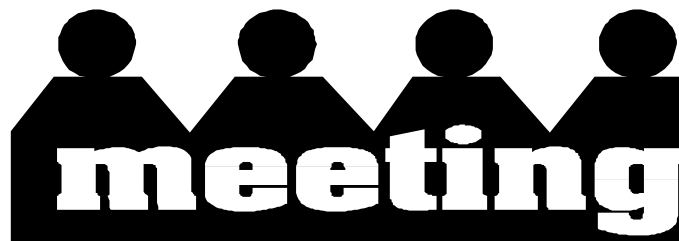
Programs for Older Adults. Older adults are often at higher risk for institutionalization. Carroll House and Rypins House are examples of transitional residential treatment programs specifically for older adults.

The programs' purpose is to divert persons age 60 and older from psychiatric hospitalization and institutionalization.

Carroll and Rypins Houses are one of the few psychosocial residential treatment facilities in the country to work with a geriatric population. Clients are referred by one of the Geriatric Teams from the City's Coordinated System of Care, and approved by the Geriatric Bed Committee. Referral inquiries can be made directly to the program. Regulations require that all admissions be voluntary.



The program offers a full treatment schedule and structure, consisting of group therapy meetings, socialization and physical activity sessions, and a range of skill-building workshops. Overall, staff works with clients to explore healthy, positive ways of living and reacting to difficult life situations.



All Welcome

VI. Focus on Community

This is the duty of our generation as we enter the twenty-first center – solidarity with the weak, the persecuted, the lonely, the sick, and those in despair. It is expressed by the desire to give a noble and humanizing meaning to a community in which all members will define themselves not by their own identity but by that of others.

Elie Wiesel



For too long, mental health treatment and the recipients of such treatment have been isolated from the mainstream of society. While this separation in times past was seen as protective, it has permitted the stereotypes that promote stigma and discrimination to flourish. In order to transform mental health treatment, we must transform our communities and ourselves. In order for the goal of recovery to be realized, recipients of mental health services must be welcomed citizens in the community of their choice.

A. **Community Integration**

Community Integration entails assisting individuals in linking with housing, employment, transportation, social services, recreational activities, educational opportunities and social networks in their neighborhoods. Being integrated into the community includes being connected to other people with shared interests, experiences, goals and/or beliefs and means having friends and supporters aside from mental health professionals.



Community Integration is a right of people with psychiatric disabilities to live in the community and have the same opportunities as anyone else. Community integration includes the concepts of place (i.e., living in the community) and participation (i.e., self-directed engagement in community life and involvement in fulfilling social roles such as employment, family, and citizenship). The right to community integration is based on the Americans with Disabilities Act (ADA) and the *Olmstead vs. LC* Supreme Court ruling and spurred by major policy initiatives such as the presidential executive order following the Olmstead ruling and the President's Mental Health Commission Final Report.

Community Integration involves a shift of focus from the individual being in a professional mental health environment to being part of a general community.

The Community Integration Collaborative at the University of Pennsylvania is about promoting the community integration as it pertains to people with psychiatric disabilities. Its purpose is to lead the mental health field in identifying and eliminating barriers to community integration and in developing supports that facilitate community integration outcomes and bring about meaningful changes in the lives of people with psychiatric disabilities.

The Collaborative focuses its efforts on the following areas: Community Integration Concept and History, Employment, Housing, Education, Citizenship, Language and Community Integration, the Americans with Disabilities Act and the Olmstead decision, Social Roles, Peer Support, Self-Determination, Stigma and Spirituality/Religion.

Helping to expand on the concept of community integration is an emerging dialogue around connectedness and citizenship and redefining social integration.

"Social integration is defined as a process, unfolding over time, through which individuals who have been psychiatrically disabled increasingly develop and exercise their capacities for connectedness and citizenship. Connectedness denotes the construction and successful maintenance of reciprocal interpersonal relationships. Social, moral, and emotional competencies are required to maintain connectedness. Citizenship refers to the rights and privileges enjoyed by members of a democratic society and to the responsibilities these rights engender."²⁵

One area where community integration and social integration intertwine is a practical focus on what a person can do and be in everyday life. What one can do or be is a function of competencies and opportunities. Opportunities are provided in the social environments such as work, home, etc.

Resources

The UPenn Collaborative on Community Integration is the Rehabilitation Research and Training Center (RRTC) Promoting Community Integration of Individuals with Psychiatric Disabilities.

<http://www.upennrrtc.org>

²⁵ Ware, N., Hopper, K., Tugenberg, T., Dickey, B. and Fisher, D., (2007). Connectedness and Citizenship: Redefining Social Integration. *Psychiatric Services*, 58(4), 469-474

B. Community Development

Bruce Anderson of Community Activators describes Community Development as *"increasing the capacity of the community to include all citizens in the rhythms and routines of community life."*²⁶ Using this approach we help the community group to move from *"this person is not part of the community because they have a problem"* to *"this person is not part of the community because the community is not prepared to be welcoming and inclusive."* This perspective recognizes that all citizens have a gift to contribute to the community.²⁷

C. Fighting Stigma and Discrimination²⁸

Many of the problems confronting people with mental illness result from public misunderstanding about psychiatric disorders. At the most harmful levels, these misunderstandings rob people of rightful life opportunities. At more benign levels, they result in a failure to prioritize mental health issues in the political arena. ...Public ignorance translates to stigma, prejudice, and discrimination that permeate common assumptions about mental illness and undermines equal opportunities.

Pat Corrigan

Replace the Attitude. If individuals in targeted power groups had more positive expectations about people with mental illness, then many of the goals blocked by this group would diminish. In particular, landlords who endorse positive expectations about independent living and employers who agree that people with mental illness can be competent workers would lead to a living wage, meaningful occupation, and comfortable housing for many more people with mental illness. A combination of two strategies - contact and education - will help achieve these goals when presented to groups of landlords and employers. People with psychiatric disabilities telling their

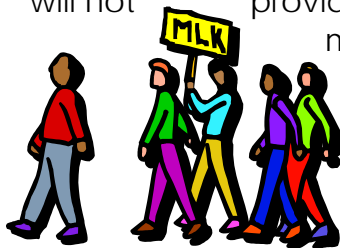
²⁶ Anderson, Bruce. *Strategic areas for increasing community development capacity in social service organization*. Published by Community Activators and is available at <http://www.communityactivators.com/downloads/StrategicCommDev.pdf>

²⁷ Anderson, Bruce and Gina. *Seeds for recovery: Using core gifts to inspire hope and action*. Published by Community Activators and is available at <http://www.communityactivators.com/downloads/SeedsForRecovery.pdf>

²⁸ Corrigan, Pat.). *Beat the Stigma and Discrimination! Four Lessons for Mental Health Advocates*, University of Chicago Center for Psychiatric Rehabilitation and The Chicago Consortium for Stigma Research.

stories to landlord and employer groups, especially focusing on the myths of mental illness and corresponding facts that challenge them, can have significant impact. Contact effects are further enhanced when the person telling his or her story is actually from the landlord or employer's community. The short-term impact of the person's story is further enhanced if some kind of mechanism for ongoing interaction is formed. For example, the employer group might start an action committee comprised of people with psychiatric disabilities and employers who will work as peers to rectify disparities in their community.

Attitude Be Damned: Stop the Behavior. Advocates need patience and a willingness to work with targeted power groups in order to get these groups to adopt a more enlightened perspective. Unfortunately, some members of targeted power groups regularly perpetuate such disrespectful and stigmatizing messages about people with mental illness such that the kind of patience needed for attitude change will not suffice. In these cases, a well-coordinated effort at an economic or political boycott is needed. Media outlets need to be told that a sizeable part of their market (people with psychiatric disabilities and others concerned) will no longer purchase their products or services if specified messages continue. Similarly, elected officials must be informed that members from a sizeable bloc of their constituencies will not



provide support in the upcoming election unless certain messages change. Both these approaches are largely reactive, requiring specifically crafted messages to the businessperson or politician that convey group dissatisfaction and subsequent consequences. Advocates need to work now to recruit more people of like mind to join the effort so that their economic and political base will broaden and be in place when protest is needed. Advocates also need to educate the public as to the size and potency of this kind of coalition.

Action Steps.

- Formulate an Advocacy Agenda (more jobs, better housing)
- Identify the behaviors and groups that block the advocacy goals
- Determine causes of behavior (e.g., attitudes, stereotypes, economy, size of business, etc)
- Pick a strategy (Education, contact with people with disabilities, protest, demonstrations, boycotts, letter writing, etc)

- Evaluate your action plan

Community Service Projects that provide Contact with People. As mentioned by Pat Corrigan, stigma and discrimination are most effectively combated when members of the target group have ongoing interactions with mental health consumers. If consumers worked alongside non-consumers involved in giving back to the community, the stereotype that consumers only take from the community would be shattered and replaced with the observation that consumers contribute to a healthy community.

Action Steps.

- Convene a group of interested consumers and possible supporters such as your local Volunteer Center and your Pre-Vocational program
- Brainstorm and identify projects that consumers could be involved in and that are of interest to consumers
- Identify resources needed and ask for donations
- Provide peer support to consumers in starting the project that may include accompanying them to the site and providing direction and encouragement
- Monthly support groups for consumer participants can be useful to encourage and troubleshoot issues that may de-motivate participants



Examples.

S-Cubed – Contra Costa County, CA

S-Cubed which stands for Spirit, Service and Support in Contra Costa County – One group of consumers from a Community Center attended Neighborhood meetings and agreed to cooperate to promote neighborhood safety and pick up trash (with neighbors) on Fridays. By attending the meetings in person, the Community Center was seen as a solution and a part of the neighborhood, rather than an intrusive problem. Another group made greeting cards and arts & crafts projects for local nursing home residents.

Make A Difference Day²⁹

Concord Community Center (Contra Costa County) consumers identified an area of a parking strip that was filled with weeds and old car parts. They got permission from the owner to remove the weeds, install black weed block covered with wood chips. In an adjacent lot, they planted donated plants to beautify the area. On "Make a Difference Day", more than a dozen consumers arrived to haul weeds and dirt and install weed block. Afterward there was a pizza celebration. Now when members come to the Center, they see first hand their constructive work.

Resources

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<http://www.casra.org/Advocacy/a-frame.html> (scroll all the way down)

Resource Center to Address Discrimination and Stigma (ADS Center) offers resources to implement Anti-Stigma Campaigns, including the Eliminating Barriers Initiative (EBI).
<http://www.adscenter.org>

Stamp Out Stigma is a community advocacy and educational outreach program dedicated to eradicating the stigma associated with mental illness.
<http://www.stampoutstigma.org>

Mental Health Association in San Diego County administers the Erasing The Stigma of Mental Illness (ETS) campaign. ETS educates interested business and community leaders about mental illness and gets them involved in their own communities.
http://www.mhasd.org/About_Us/Local/Education/education.html

²⁹ Created by USA WEEKEND Magazine, 'Make A Difference Day' is the most encompassing national day of helping others -- a celebration of neighbors helping neighbors. Make A Difference Day is an annual event that takes place on the fourth Saturday of every October.<http://www.usaweekend.com/diffday>

Appendix

Resources

Advance Directives

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Websites of Interest

CA Network of Mental Health Clients
<http://www.californiaclients.org>

HealthyPlace. Com Depression Community
<http://www.healthyplace.com/Communities/Depression/mhrecovery>

Mental Health Recovery & WRAP
<http://www.mentalhealthrecovery.com>

Mental Illness Education Project
<http://www.miepvideos.org>

NAMI of Santa Cruz County
<http://www.namisc.org/MentalHealthRecovery.htm>

National Association of State Mental Health Directors
<http://www.nasmhpd.org>

National Empowerment Center website.
<http://www.power2u.org>

Patricia Deegan, Ph.D.
<http://www.patdeegan.com>

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www.projectresilience.com

ResilienceNet
<http://resilnet.uiuc.edu>

Resiliency in Action
<http://www.resiliency.com/>

Resilience - Youth and Family

Family life: Strengthening family and youth
http://www.clemson.edu/fyd/family_life.htm

Stigma/Discrimination Campaign Resources

Resource Center to Address Discrimination and Stigma
<http://www.adscenter.org/>

Stamp Out Stigma
<http://www.stampoutstigma.org>

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About CASRA

The California Association of Social Rehabilitation Agencies is a statewide association of non-profit agencies providing rehabilitation and support services for clients of the public mental health system. The purpose of CASRA is to promote the development of community-based systems of services that provide choices for consumers, and which are based upon the promise of growth and recovery.

Member agencies offer a range of services including supported housing, supported employment and supported education; peer support and self-help services; outreach, advocacy and service coordination; intensive community services and crisis and transitional residential treatment alternatives to hospital and other institutional care settings.

Established in 1969, CASRA has consistently been on the forefront of developing innovative responses to the needs of adults with psychiatric disabilities. Since 1989, CASRA has been affiliated with the United States Psychiatric Rehabilitation Association (formerly IAPSRs) as the California chapter.

In 2002, CASRA produced a Curriculum for the Psychosocial Rehabilitation Practitioner. The Curriculum is designed for in-service training and for certificate and associate degree programs at the community college level. An adaptation of the curriculum has been designed specifically to help persons meet the qualifications and successfully pass the exam for the national Certification of Psychiatric Rehabilitation Practitioners (CPRP).

CASRA is currently developing training and education resources based on principles of a culture-centered approach to recovery.

For more information visit www.casra.org or call 925-229-2300.