



RECOVERY TO PRACTICE
Resource Center for Behavioral Health Professionals

FREQUENTLY ASKED QUESTIONS (FAQs)

**Thirty of the Most Frequently Asked Questions
About Recovery and Recovery-Oriented Practice
(along with some beginning answers)**

July 2011

1. Do people really recover? And if so, why don't I see them?
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3. How is recovery-oriented care different from simply implementing evidence-based practices?
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27. How does the relationship between the practitioner and the service user change in recovery-oriented practice?
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29. What kind of culture change is required to support recovery-oriented practices?
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1. Do people really recover? And if so, why don't I see them?

Philippe Pinel, often considered the father of psychiatry, wrote in 1808, “To consider madness as a usually incurable illness is to assert a vague proposition that is constantly refuted by the most authentic facts” (Pinel, 2008). Pinel, in fact, reported a recovery rate of 93 percent for people who had been admitted to his hospital within a year of onset of their mental health difficulties and who had not received prior treatment at an asylum (treatment that was often violent and that Pinel viewed as detrimental). Similar recovery rates were seen in other moral treatment retreats prior to the creation of large State mental hospitals, which unfortunately came to resemble the pre-moral treatment-era asylums in providing primarily custodial care in overcrowded institutions.

It is from this approximately 100-year period of large asylums, between 1850 and 1950, that we owe our beliefs about the incurability of mental illnesses and why the questions above have become two of the most common raised by mental health professionals when confronted with the long-term outcome literature that has been consistently produced since the 1970s (Carpenter & Strauss, 1974; Harding et al., 2005; Strauss & Carpenter, 1974).

This literature suggests that between 45 percent to 65 percent of people diagnosed with schizophrenia—the most severe of the severe mental illnesses—will recover from the disorder over time. The recovery rate Harding and colleagues (Harding, Brooks, & Ashikaga, 1987; Harding et al., 1987b) found in rural Vermont was around 65 percent, while a World Health Organization study found about 45 percent in Boston and Washington, D.C. (World Health Organization, 2001). These are the percentages of people who

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recovered fully (that is, no longer appeared to have any signs or symptoms of mental illness). The percentages for people who experienced significant improvements would be even higher than that. In contrast, most studies *found only about 20 percent to 25 percent of any given sample experiencing a **deteriorating course** over time* (Carpenter & Strauss, 1991; Davidson & McGlashan, 1995; Harding et al., 1987a; Harding et al., 1987b).

Despite the consistent literature documenting recovery over the last 40 years, this good news still has not made its way into the training of most mental health professionals. So, many mental health professionals, when exposed to this body of research, ask the questions above. If so many people get better, then why don't I ever see them? A reasonable enough question, to be sure, and one to which there are several answers.

The first answer comes from a husband-and-wife team of statisticians in the 1980s, Cohen and Cohen (1984), who wrote the seminal paper cited below about what they described as the "clinician's illusion"; in essence, a sampling error of patients within the clinical setting. The Cohens showed that people who work in clinical settings, i.e., clinicians, see people who are ill *when* they are most ill and often *only* when they are ill; clinicians do not see people who are, or **when** they are, well. If I only see you when you are sick, I am going to assume that you are always sick. And if I work in a clinical setting, and therefore typically see people when they are sick, I am likely to draw the erroneous conclusion that the people I see are always sick. What I may not stop to consider is that I am not seeing people who are well because they are, in fact, doing well.

Clinicians do not see people who are, or when they are, well.

In less-ambiguous or better-understood illnesses, there may be no such illusion. For example, for a pediatric nurse practitioner in an endocrinology clinic, a reasonable assumption when she doesn't see a teenager in her clinic is that the teen is probably doing fine in managing his or her diabetes. When the teen gets sick, then she would see him or her, either in the clinic or in the hospital, but otherwise, odds are that things are basically okay. What has been different in psychiatry is the legacy of the 100-plus years previously noted, during which people diagnosed with serious mental illnesses were confined to institutions and assumed to be chronically and seriously ill, often for the remainder of their adult lives.

This 100-year period of institutionalization both gave birth to, and perpetuated, the belief that these conditions were permanently disabling. As it turns out, what was permanently disabling was being confined to an institution, not the conditions themselves (Davidson, Rakfeldt, & Strauss, 2010; Gullickson, 2004; World Health Organization, 2001). Since the end of that era, epidemiologic and longitudinal studies have found that many people do well over time, and that when they do well,

they often see no reason to seek or use mental health services (Narrow et al., 2000). As a result, mental health professionals in fact **do not** see these people, at least not as patients in public sector settings. They do, of course, encounter people with mental health conditions all the time, in their families, in the grocery store or mall, at the Parent–Teacher Association or swim club meetings, at work and at social events, in their neighborhood, and at church, synagogue, or mosque. But since people do not introduce themselves as having a history of psychiatric disability, there is no way of knowing that history unless the person chooses to disclose it.

Some people respond to the explanation provided above by saying that their own experiences suggest a different picture, in which they encounter people who had dropped out of treatment but who were having even more difficulties than when they were in care, rather than fewer. They wonder about the people who they see on the streets, in homeless shelters, or in prisons, or who show up at a later time having experienced significant deterioration in both their mental and physical health; phenomena that appear to be more common, perhaps, in urban areas. Doesn't the presence of such people with serious mental illnesses who, by almost any criteria, are *not* recovering over time call into question the very notion of recovery? More succinctly stated: is the clinician's illusion really an illusion after all?

It unfortunately is true that most, if not all, of us have had such experiences of seeing people who are not in treatment and who are struggling with significant difficulties. It is a tragedy that there are any such people out there, but this is not only due to the severity of the mental illness. It also is due to multiple system failures and a cascade of harmful social determinants, such as poverty, unemployment, limited education, prejudice and stigma, poor health and lack of access to health care, and other social inequities.

There are, however, many **more** people out there doing well—but you would have no way of knowing who they are unless they told you about their experiences with illness. And since people are more likely to remember those people they see over and over again, they tend to generalize from those clients who may be having the most difficulty to all clients, past, present, and future. As a consequence, we assume that the folks who we see who are still struggling with significant difficulties are in the majority, while research suggests they are not.

So while the people we see on the streets, in homeless shelters, in prisons, or in hospitals are certainly there, they comprise “only” about one out of four or five of the people who have had the illness for that period of time. If you stop to consider how many people you typically will see over a 20-year career in mental health, and compare that to how many people you have seen who remained very sick for an extended period of time, you most likely will end up with around the same number. This number is, of course, not trivial (which is why we put quote marks around “only”), and the challenges faced by these individuals are not to be overlooked or

trivialized. If anything, their presence should inspire us to redouble our efforts to promote recovery among **all** people affected by mental illness.

But the fact that one out of four or five people may experience significant distress and disability for an extended period of time with our current treatments does not justify rejecting the reality of recovery. Research shows that many of those deemed most profoundly disabled by the illness at any given time nonetheless recover fully at a later point, meaning that there is currently no way to predict who will recover, when, or to what degree. To treat any individual as if his or her fate were predetermined and hopeless based on a psychiatric diagnosis—as in any other chronic illness—is to limit the resources and imagination of both clinicians and clients. To apply this thinking to the entire range of people with the disorder also goes against the primary ethical responsibility of health care practitioners, to “first, do no harm.”

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As a result of being underresourced and overworked—as well as having few, if any, opportunities to see people recovering and doing well—practitioners have been denuded of hope, as many clients have as well. Yet, as in many other serious health conditions (of which serious mental illness is one), a broad range of clinical outcomes is possible at any juncture. Despite the medical breakthroughs of the last half-century, for example, many people continue to die of cancer. This fact does not dissuade us from doing everything we can to ensure their access to effective care, to encourage quality in their lives, and to promote their recovery in the face of serious illness; neither should it do so when the illness in question is a mental illness.

Article on Clinician’s Illusion:

P. Cohen & J. Cohen. (1984). The clinician’s illusion. *Archives of General Psychiatry*, 41, 1178–82.

A selection of outcome studies from the past 30 years:

Ciampi, L. (1980). The natural history of schizophrenia in the long-term. *British Journal of Psychiatry*, 136, 413–20.

Harding, C.M.; Brooks, G.W.; Ashikaga, T.; Strauss, J.S.; & Brier, A. (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, 718–26.

Harding, C.M.; Brooks, G.W.; Ashikaga, T.; Strauss, J.S.; & Brier, A. (1987). The Vermont Longitudinal Study of persons with severe mental illness, II: Long-term

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For further general reading:

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2. Is recovery evidence-based?

Although there is no single agreed-upon definition for “evidence based,” people want to know how the recent emphasis on evidence-based practice relates to the notion of recovery and the transformation to a recovery orientation called for by the President’s New Freedom Commission on Mental Health (DHHS, 1999, 2003) and the subsequent Federal Action Agenda (SAMHSA, 2005). This issue is especially of

concern to those practitioners who have devoted the past 5 or so years of their professional lives to learning and implementing evidence-based practices. Is this shift to recovery based in scientific evidence, and have practices that claim to promote recovery been subjected to rigorous evaluations? These are indeed important questions.

While the relationship between recovery and scientific evidence may be multidimensional and complex, this response will feature a few straightforward answers to a few common questions. Readers who are interested in exploring this issue further, and who are interested in the ways in which recovery and evidence-based medicine can complement and enrich each other, should refer to the suggested additional reading, which offers more of a historical perspective as well as a few illustrative examples.

Is there an evidence base for recovery? Yes. What that means in practice depends upon how we define recovery. If by “recovery,” we mean the traditional notion that people “get over” or “heal from” having a serious mental illness, the longitudinal research discussed above in response to Question #1 suggested that recovery is just as common, and in

fact is significantly **more** common, than the chronic and deteriorating course once

Recovery is, in fact, significantly more common than the chronic and deteriorating course once thought to characterize mental illness.

thought to characterize mental illness. This evidence base for recovery has been seen historically, consistently, and cross-culturally (DHHS, 1999; Lin & Kleinman, 1988; World Health Organization, 2001).

The answer to this question is also “yes,” if by “recovery,” we mean the more recent notion captured in the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) 2006 Consensus Statement that refers to “*a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential*” (SAMHSA, 2006). This form of recovery is seen every day in the lives of tens of thousands of individuals living *with* and managing mental illness (the majority) outside of hospital settings, which were once thought to be required by the nature of these conditions. Most of the people with mental illness live outside of chronic care, with their illnesses affecting them in different ways, to different degrees over time. For these people, living with a serious mental illness is more like living with asthma, HIV, or some forms of cancer, than recovering (i.e., “healing”) from it. While the condition may pose some limitations and certainly has significant impact upon people’s lives, it remains possible and important for the person to live a meaningful and self-determined life nonetheless.

For further reading:

L. Davidson; R.E. Drake; T. Schmutte; T. Dinzeo; & R. Andres-Hyman. (2009). Oil and water or oil and vinegar? Evidence-based medicine meets recovery. *Community Mental Health Journal*, 45, 323–32.

- 3. How is recovery-oriented care different from simply implementing evidence-based practices?**
- 4. How is recovery different from psychiatric or psychosocial rehabilitation?**

First, it is important to acknowledge that there is some overlap between recovery-oriented practice and certain existing practices that are evidence-based, derived from the psychosocial rehabilitation tradition, or both. While these fields have root in different disciplines, and the concepts are separate, they are not mutually exclusive—but neither are they mutually dependent. The first two e-newsletters from the Recovery to Practice (RTP) Initiative (SAMHSA, 2010) highlighted the evidence-based practices of supported employment and supported housing. Both of these practices originated within the psychosocial (or, more recently, psychiatric) rehabilitation field, and both are consistent with recovery-oriented values and principles. Such community-based supports can be provided in other areas as well: promising advances have been made in the areas of supported education, supported spirituality, supported parenting, and other ordinary, everyday—but important—human pursuits, such as supported voting and pet ownership. All of these practices, when offered in a person-centered and empowering manner that focuses on inclusion in community life, can be viewed as recovery-oriented practices.

But what about other well-established or sufficiently empirically supported practices? What about the assertive community treatment (ACT) model that was developed by Stein and Test (1980) in Wisconsin more than 40 years ago, for example, or the psychosocial clubhouse model that originated with Fountain House in New York City, N.Y., more than 50 years ago? ACT offers a comprehensive and community-based service modality that has been, and can continue to be, a vehicle for the development and delivery of supported housing or employment, or any of the other supported activities that we previously mentioned. It has a robust evidence base attesting to its effectiveness in keeping people out of the hospital, out of jail, and off the streets (Bond et al., 2001). Psychosocial clubhouses similarly can offer supported housing, supported employment, or other interventions for their members, and have shown much success in affording their members more of a life in the community than they otherwise would have (Macias et al., 1999). These two models, in particular, have been beacons of the deinstitutionalization and community support movements that preceded (some would say, “paved the way for”) the recovery movement. Given these track records, then, isn’t it enough for a system to ensure access to high-quality ACT teams and psychosocial clubhouses, especially if these programs hire some peer staff?

Similar arguments could be made for an array of other well-studied, or at least, well-established, practices, such as disorder-specific cognitive-behavioral psychotherapies, psychiatric medications, multisystemic family therapy, wraparound services, and perhaps the most widely disseminated, if ambiguous, practice of all, case management. Wouldn't a transformed system of care offer people with mental health conditions ready access to such an array of high-quality and effective services? Given that implementing, sustaining, and ensuring the quality of such an array of services is no small task, should we really expect anything more of a recovery-oriented system of care?

One answer to this question can be found at the end of the first paragraph of this response: "All of these practices... can be viewed as recovery-oriented"—**but only** "when offered in a person-centered and empowering manner." So what does it mean to offer mental health services in a person-centered and empowering manner? This question gets to the heart of the issue and offers some ways of distinguishing recovery-oriented practices from the psychosocial rehabilitation and evidence-based practices that may not qualify as being recovery-oriented.

What exactly does the recovery movement add? First and foremost, the recovery movement was—and is—a civil rights movement (Davidson, 2006). It is not only a quality-improvement initiative, although it promises to enhance the quality of care. It also does not refer directly to the development of new services or supports, although it certainly generates rich implications for new services or supports that might be developed in the future. Finally, it is not based immediately on any advances in treatment (e.g., newer medications) or breakthroughs in research (e.g., understanding the causes of mental illness)—although it *is* supported by an extensive body of research on outcomes in serious mental illnesses that has been accumulating since the 1970s (Carpenter & Strauss, 1991; Davidson & McGlashan, 2005; Harding et al., 1987; Harding et al., 1987b; Hopper et al., 2007; World Health Organization, 2001).

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Instead, what the recovery movement has done is focus our attention, in an immediate, direct, and sustained way, on the various ways in which social conditions and social inequities have mitigated against recovery and community inclusion and on the ways in which people with mental health conditions, their loved ones, mental health practitioners, and society at large can identify, deal with, and overcome these forms of discrimination. Within that context, recovery-oriented care then focuses on the ways in which each person can deal with, and overcome, the remaining challenges posed by the illness itself, while promoting areas of competence and strength (DHHS, 2003; SAMHSA, 2006).

Just as people with diabetes have to manage their own blood sugar and health through diet, exercise, and medication, recovery becomes primarily the responsibility of the person with the condition, not that of the practitioner, no matter how well-intended and capable the practitioner may be. While evidence-based practice initiatives and the field of psychiatric rehabilitation have emphasized what practitioners can do to assist people in recovering from a mental illness, the recovery movement emphasizes what people with mental illnesses need to do—their rights and responsibilities—to get their lives back, both from the illness itself and from the range of secondary effects associated with the illness. For many people, these effects include a loss of hope and dignity, a sense of social rejection and shame, and a legacy of low expectations that have resulted from stigma, discrimination, and interactions with a mental health system that has focused on deficits, diseases, and doom, rather than on personal strengths, resilience, and hope for the future.

If recovery is the responsibility of the person, and the provision of evidence-based and psychiatric rehabilitation practices is the responsibility of the practitioner, do we even need a notion of “recovery-oriented practices”? What sense does this combined phrase make when we have drawn such a dichotomy between “recovery”

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and “practice”? Briefly stated, recovery-oriented practices are those practices that are based on the understanding that recovery is the purview of the person with the condition and that the role of the practitioner is to be supportive of the person’s efforts

to make sense of, deal with, and overcome the illness. This expertise, can, of course, include more traditional treatments like medication and psychotherapy when the person in recovery has indicated that would be helpful. When the person has lost all hope and/or any belief in his or her ability to recover, the practitioner’s initial role may be to offer and carry hope for the person, and to believe in the person even when he or she may not believe in him- or herself. It may also fall to the practitioner to engage a reluctant, untrusting, or traumatized person in a safe, trusting, and accepting relationship or environment as a first step toward learning about and pursuing recovery. But through all of these efforts, the recovery-oriented practitioner remains mindful of the fact that mental health services are to be supportive of and useful to the person him or herself—meeting the person “where s/he is.”

In the early days of psychosocial rehabilitation, a member of Fountain House commented, “Rehabilitation is not something that you can do **to** a person.” Rather, it is something in which the person must be engaged as an active participant. The same, and more, can be said about recovery-oriented practices. They are, by

definition, not interventions that we can do **to** people, even if we argue that they are interventions to which a person has, at least in principle, agreed. That's because mental health care is not like surgery. More like the rehabilitation phase that follows surgery, recovery requires the person not only to be an active participant but to also actually drive the process.

Recovery is hard work: I have to be the central and guiding force in my own recovery, for at least two reasons. One, I know myself better than anyone else does. I know best what pace I can take, which challenges to pursue, to what desired ends, and what might be helpful to me, or not helpful, in this process. Second, recovery involves rebuilding one's self and one's identity, as well as one's life. Once I am an adult, I am to be the primary author of my own life. Practitioners bring a wealth of knowledge, experience, and skill to the relationship and can be extremely valuable allies in recovery. They can educate, guide, and offer me tools, and they can support and stand by me as I try to figure out how best to understand and overcome my mental health concerns. They cannot, however, live my life for me: only I can do that.

Recovery-oriented practices are based on an appreciation of the person's right to determine his or her own life, just as it is for those of us either without a psychiatric

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diagnosis or who receive their mental health care in private health care settings. Recovery-oriented care appreciates the central role that **choice** plays in defining who and what we are. For this reason, some people have suggested replacing the term "recovery" with the much clearer, and less pathology-related, term, "self-determination." Recovery-oriented practices honor the right of persons with mental illnesses to self-determination. They honor this right, not as an outcome of or reward for recovering (i.e., not once the person is well), but rather as a foundation for the person's efforts toward recovery (i.e., even while experiencing the illness). Once ravaged by the disruptions and distress caused by the illness, people recover their capacity for making decisions only by actually making their own decisions, learning about the consequences of those decisions, and re-evaluating this dynamic so that they can increasingly learn how to obtain the desired result.

While the principles remain the same, a recovery-oriented approach may need to be adapted and

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applied flexibly when working with or assisting people in acute distress or crisis, people who are unable to care for themselves, or those who have been mandated to treatment by the courts. The main point to consider is that implementing high-quality and effective psychiatric rehabilitation and other evidence-based practices is not enough to accomplish transformation if the status and role of the person in recovery is not also dramatically transformed from that of a passive “mental patient” to that of an empowered citizen. Just as in all other branches of care, person-centered, empowering care in mental health is care that is actively chosen by the person with the condition, in collaboration with a practitioner and his or her loved ones.

Thus, when trying to revise assertive community treatment to be more recovery-oriented, for example, it is important not only to look at the services and supports being offered and the desired outcomes, but also to look at the culture and processes of care. What role does the person play in determining his or her own care, not to mention his or her own life? Has the person chosen, or at least agreed voluntarily, to be on an ACT team, and, if so, for what intended purposes? Does he or she have a role, or a voice, in the course of his/her treatment? What does he or she have to gain by participating in such services, by allowing these practitioners (who begin as strangers) into his or her life?

Similar questions can be asked about all other evidence-based and rehabilitative interventions and activities, from supported employment to individual therapy. And when these questions can be answered in a way that honors the dignity, agency, and self-determination of the person being served, then we can be assured that we are on the way to a truly recovery-oriented system of care.

For further reading:

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5. **How does recovery-oriented practice relate to the medical model or clinical care?**
6. **Is the recovery movement antiprofessional?**

One source of these questions is the unfortunate reality that some practitioners view the recovery movement as “antiprofessional” or as threatening to do away with their profession, being equated in some circles with past “antipsychiatry” movements, a legacy of the origins of the movement in the early days of de-institutionalization after more than a century destructive treatment. The recovery movement, however, has since moved from its earlier separatist position to seeking to partner and collaborate with practitioners. In fact, the entire RTP Initiative would make no sense were the recovery movement and medical and clinical practice not only compatible, but actually synergistic. Why bother to develop and train professionals in recovery-oriented practice if there were no role for professionals to play in promoting recovery?

In order to understand the tense relationship between people in recovery and the formal mental health system, it's crucial to have a historical perspective. The recovery movement in mental health was first and foremost a civil rights movement founded and led by people in recovery themselves (Davidson et al., 2010). Many of the founders of this movement had been mistreated in the mental health system of the mid-20th Century, most often being hospitalized and medicated against their will and having suffered a range of indignities, humiliations, deprivations, and abuses in understaffed and overcrowded, largely custodial institutions (Davidson et al., 2010). It therefore is no surprise that some of the early rhetoric of the recovery movement came across as antiprofessional and as calling into question, if not blatantly critical of, the medical and clinical care that was being provided at the time. In the process of reclaiming their rights to full citizenship and community membership, ex-patient

advocates denounced the system of care that had made their advocacy necessary. It had been mental health institutions and professionals acting as agents for society that had taken away their liberty and subjected them to unhelpful, and at times extremely injurious, treatments. It was therefore these same institutions and professionals that became the focus of their criticisms and their efforts to reform practices that they viewed as performing social control, rather than medical or clinical, functions.

More recently, another source of the perception that the recovery movement is antiprofessional stems from complaints expressed about mental health professionals' use of the so-called "medical model." This, too, is an unfortunate legacy of the history of psychiatry over the last 40 or so years, during which the neuro-biological model of mental illness and its treatment were ascendant to the point

A holistic medical model is compatible with the vision of the recovery movement that focuses on the whole person.

of overshadowing other perspectives. As a result, the term "medical model" came to be used to criticize and disparage an overly narrow focus on the presumptive biological nature of mental illness and on some segments of the field's almost exclusive reliance on psychiatric medications as the only effective treatment.

But most physicians, including psychiatrists, are not trained in such a narrow version of a "medical model." The medical model in which most healthcare professionals—regardless of discipline—are trained is a "bio-psycho-social model" that addresses the biological components of disease and disability, but also incorporates factors and interventions that speak to the psychological and social dimensions of human health and illness as well. Such a holistic model is compatible with the vision of the recovery movement that focuses on the whole person, even though there may remain some differences in emphasis. In fact, recovery-oriented practice incorporates medical approaches in its holistic focus. One possible difference is that the primary focus of the bio-psycho-social model is on the pathophysiology of disease, deficit, and dysfunction, although there remains room in such a model for the active role of the person in adapting to or recovering from a given condition. As a model for self-care, the recovery model, in contrast, focuses less on the causes of disease (which remain poorly understood) and more on what a person can and may need to do to deal with and overcome his or her difficulties. Rather than conflicting or competing, it is possible to view these models as complementary and as having much to offer each other in exchange.

The recovery movement encourages mental health professionals to practice in accord with their own highest professional principles and ethics.

It is just as short-sighted to view recovery as antiprofessional or antimicrobial as it is to view the medical

model as promoting a narrow and restrictive view of treatment and rehabilitation that involves no more than medication adherence. Rather than being antiprofessional, the recovery movement encourages mental health professionals to practice in accord with their own highest professional principles and ethics. Recovery advocates invite practitioners to assess, explore, understand, and assist, as requested, in all areas of a person's life in which he or she is experiencing distress and/or dysfunction. This is entirely consistent with the traditional aims and values of the science and art of medicine, despite the fact that day-to-day medical or clinical practice does not always live up to these ideals. Professionals who strive to embody the "bio-psycho-social model" benefit from viewing recovery advocates as their partners in ensuring that adequate attention is paid to all aspects of patients' lives, including but not limited to its biological components.

How can professionals and recovery advocates collaborate? This leads back to the question of how the recovery movement relates to medical or clinical practice. Perhaps the nature of this partnership is best exemplified through a reconfiguration of the relationship between recovery and treatment. From the perspective of a narrow "medical model," it might seem at first that recovery as a goal of care can be viewed as coming *after* active treatment. In fact, some professionals who think that they are "doing recovery already," view recovery as the end result of active treatment and rehabilitative efforts on their part. From this perspective, it seems straightforward and simple to add "recovery" as a new dimension to existing treatment plans. That is, in addition to prescribing medications to reduce symptoms, we can expand the treatment plan to include the provision of supported employment, thereby transforming the care plan into a recovery-oriented document. The care plan remains focused on what we as clinical professionals need to do to foster the person's recovery. The person's role, in this view, is primarily to do what professionals prescribe. Then when people do not do what professionals prescribe, they run the risk of being described as "noncompliant" or, more recently, as "not working on their own recovery."

There are two basic problems with this view, and two ways in which recovery-oriented practice reconfigures this relationship between treatment and recovery. The first problem is that we, as medical or clinical professionals, cannot "do" recovery. For some people who experience an episode of mental illness and respond quickly to treatment, the model described may work fine. For these people, returning to school or work, resuming social relationships, pursuing interests, all such activities and responsibilities may be put temporarily on hold until the episode resolves, and then may be picked back up following successful treatment. For many people experiencing serious mental illnesses, though, this model is inadequate. For them—for those people whose condition does not respond either quickly or fully to available treatments and services—life cannot be put on hold indefinitely, and the role of the medical or clinical professional has to change.

For much of the past 40 years, the dominant model of what professionals were asked to do for people with serious mental illnesses was to “maintain” them in the community, to reduce and contain the symptoms as much as possible and otherwise to accept that the person’s life would be limited, if not empty. But it was precisely people with serious mental illnesses who advocated for community-based alternatives to long-term hospitalization 40 years ago, and the same people who are advocating now for more of a life in the community than “maintenance” allows. We are limited in the degree to which we and our treatments can cure serious mental illnesses. This does not mean, however, that people with these conditions necessarily limit their lives to attending appointments with behavioral health professionals.

What advocates are promoting now is a full, meaningful, and self-determined life in the community—the same

What advocates are promoting now is a full, meaningful, and self-determined life in the community.

kind of life that all of us want, regardless of psychiatric status. Once that is accepted as the goal of behavioral health care, we can begin to see how the relationship between treatment and recovery changes. If the goal of mental health care is to eliminate mental illness, then it makes sense to view treatment as leading to recovery. But if the goal of mental health care becomes a full life in the community, for many people that goal cannot be accomplished through active treatment alone. Active treatment with medications, therapists, support groups, and more may remain crucial, even essential, for the person to have a chance of leading a full life, but it alone is not enough. What is required also is for the person to assume responsibility for, and take an active role in, learning about, dealing with, and overcoming the medical, social, and psychological effects of the condition and its sequelae; to be “in recovery” in the face of ongoing challenges. For such people,

A treatment plan that only stipulates what other people will do is not sufficient for the goal of living a full life in the community.

recovery does not come after, and is not the result of, treatment. For individuals with prolonged conditions, a treatment plan that only stipulates what professionals will do is not sufficient for the goal of living a full life in the community.

The second shift that is required is in perspective. The person primarily responsible for achieving that goal is me, not any of the professionals who provide care to me—and therefore, the person who should primarily drive the formulation and implementation of that plan should be me as well. What makes a treatment plan a treatment plan is that it is a plan for what treatments will be provided by whom. What makes a recovery plan a recovery plan is that it is a plan for me, and my

support team, oriented to helping me to live my life as fully as possible in the way that I want. That does not mean that a treatment plan is irrelevant or no longer needed. Rather, it means that a “treatment” plan may be one component of an overall recovery plan, that component that outlines what treatments will be provided, by which professionals, and for what purposes (and which satisfies both Joint Commission and Medicaid requirements). In a reverse of the traditional logic, treatment becomes only one tool—even if it is an extremely valuable tool—for my ongoing recovery.

Tacking recovery onto a treatment plan may seem to make sense from the perspective of a practitioner. But from the perspective of the person, the question is rather how (and which) treatments, services, and/or supports might fit into and support my recovery. While from the perspective of a practitioner, I may be viewed primarily as a patient who has an illness and who secondarily is trying to live his or her life, from my own perspective, I am first and foremost a person who is living my life and who secondarily has to deal with a mental health condition within that context. What may be confusing about the notion of “recovery-oriented practice” is that it challenges professionals to approach their medical and clinical practice from the perspective of the person with the condition, understanding that he or she is the driver of the process and the key decision maker. The practitioner, as much as possible, takes on the role of consultant. After all, professionals do not lead lives *for* people in recovery as they decide what to do on a Sunday morning, or how to handle a difficult relationship, or what to have for dinner.

What does this mean? First of all, it does not mean that the medical or clinical professional abandons medicine or any of his or her clinical knowledge, skills, or expertise. Somewhat paradoxically, it suggests rather that recovery-oriented practice is more consistent with a “preventive,” “disease management,” or “chronic

The recovery movement is not anti-professional. It values the contributions that professionals can make in reducing distress and disorder and in supporting the person’s efforts to live his or her life.

illness” version of medical practice than the acute care model that has dominated all of health care for the last half-century. For people for whom mental illness is not an acute condition, the core care provided cannot be

conceptualized as acute care. Again, as in asthma, it is a long-term condition that must be managed and may be punctuated by acute episodes. But constantly reacting to a crisis that may or may not exist is no way, and is an *inaccurate* way, to live a full life. It has been a mistake in mental health to treat the person as if he or she were suspended indefinitely within an acute episode that refuses to resolve. This has led many people to put their lives on hold for years, if not for decades, waiting for the chemicals in their brain to be balanced (what Patricia Deegan has

called “the quest for chemical balance”) before they take back up their lives. This is one of the tragedies that recovery advocates are trying to change.

The recovery movement is not antiprofessional. It values the contributions that professionals can make in reducing distress and disorder and in supporting the person’s efforts to live his or her life. To the degree to which treatments are offered respectfully in support of the person’s efforts to have a life and are selected by the person from among a range of meaningful options, there need be no conflict between recovery and active treatment. In fact, when treatments are actively chosen by the person with the condition because he or she believes that there will be benefits to doing so, the person is much more likely to use the treatments as prescribed, and the treatments are much more likely to be effective (Calsyn et al., 2003; Drake et al., 2006; Kessler & Wang, 2008; Ziedonis et al., 2005).

In this way, treatment in the service of recovery (rather than as responsible for recovery) can be a collaborative enterprise from which both parties are more likely to derive satisfaction and experience better outcomes. The key is to recognize and respect the person as a person first, and only secondarily to view the person as having a mental illness. When this basic but important premise is in place (which is the current civil rights agenda of the recovery movement), then good medical/clinical care for mental illness begins to look a lot more like good medical/clinical care for other health conditions—which is, after all, the way it should be.

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7. How do you see mental health recovery interfacing with the substance abuse recovery movement?

In the United States, the mental health and addiction fields have different historical roots and traditions. These differences naturally led to two distinct groups of practitioners who have had little to do with the other specialty. If a person had both

a mental illness and an addiction, it would have been difficult for him or her to receive optimal care. Either the mental health practitioner would not have been trained to identify the signs of substance misuse and/or the addiction practitioner would not have been trained to identify psychiatric symptoms. Even when a practitioner was able to identify both disorders, the best he or she could do was to refer the person for care for the “secondary” condition by a practitioner from the other camp.

Several important developments are changing this picture. First, both fields have come to recognize the high prevalence of what are now called “co-occurring disorders,” meaning that many people with mental health conditions also have addictions, just as many people with addictions have mental health conditions. In fact, there are 5 million adults in the United States this year alone with co-occurring disorders (Center for Substance Abuse Treatment, 2007). Research has consistently shown that for these individuals to receive effective care, mental health and addiction services must be integrated (Drake et al., 2006; Ziedonis et al., 2005). Integration has been difficult, however, for numerous political, fiscal, structural, and attitudinal influences that have been hard to overcome. Previous efforts at integration also have been difficult because they have focused primarily on the etiology or nature of mental illnesses and addictions, or on the types of treatments required by each, failing to establish a common ground that would provide a foundation for integration. As long as the focus has been on the nature of the illness or on the treatments required, historical differences have outweighed commonalities, leaving the fields splintered.

Within the past decade, though, the emergence of a recovery movement in both the mental health and addiction fields has begun to offer a new organizing principle for bringing these two disparate worlds together. As the integration of care has yet to be achieved by focusing on the nature of the disorders being treated, perhaps concentrating on the processes of recovery, healing, and community inclusion will provide the needed bridge. As a core principle of the recovery movement suggests, identifying and building on strengths can often accomplish things that attending to deficits and dysfunction have been unable to do. What results is recognition that, while mental illnesses and addictions might be different from each other in important ways—especially when viewed through the lens of a diagnostic manual—processes of recovery may nonetheless be very similar, and often interwoven—especially when viewed from the perspective of the person in recovery.

The emergence of a recovery movement in both the mental health and addiction fields has begun to offer a new organizing principle for bringing these two disparate worlds together.

The components of an integrated recovery vision begin with the idea that, regardless of how a person came to be in recovery from either or both mental illness and addiction, recovery is a personal and individualized process of growth for which there are multiple pathways. People in recovery from either mental illness or addiction have described recovery as a transformational process (sudden, unplanned, permanent) and an incremental process (marked by multiple phases), and recovery narratives are often filled with elements of both types of change, as well as nonlinear steps forward and missteps backwards (Deegan, 1988; Deegan, 1996; Deegan, 2001). Of central importance is the fact that within these stories, people in recovery are active agents of change in their own lives—not simply passive recipients of care (Davidson, 2003). These stories are filled with references to new perspectives and insights, important decisions, critical actions taken, and the discovery of previously hidden healing resources within and beyond the self. Recovery narratives often give prominence to the role of diverse religious, spiritual, and secular frameworks in recovery initiation and maintenance. People in recovery also note the critical roles of peer support and family or other communities in making a difference in their recovery (Allott, Loganathan, & Fulford, 2002; Davidson et al., 2005; Davidson et al., 2006a; Ridgway, 2001).

Whether they are living with a mental illness, an addiction, or both, people in recovery need to have hope (Allott et al., 2002; Phillips & B., 2009; Ridgway, 2004). They also want to manage or eliminate their symptoms, increase their capacity to participate in valued social roles and relationships, embrace purpose and meaning in their lives, and make worthwhile contributions to their communities, and experience joy and love (Davidson et al., 2006; Davidson, 2003). With this shared vision in place, differences that have historically existed between the recovery visions of the mental health and addictions systems can now provide opportunities for synergistic growth in both.

In developing recovery-oriented practices and systems that are based on this integrated vision, several guiding principles exist:

- The first is that both mental illnesses and addictions span a diversity of populations and outcomes. Basically, recovery looks different for different people.
- Second is the need to adopt a strengths-based, long-term, longitudinal perspective and to use a developmental framework for matching the person's point in the recovery process to appropriate interventions.
- Third is the impact of the environment: one must focus on person-environment fit and interactions.
- Fourth is the nonlinear nature of recovery and the fact that it is a process and a continuum as opposed to an outcome.

- Finally, as previously noted, is the importance of communities—family and friends, professional involvement, peer support, education and work, and spirituality—in supporting the recovery process.

Recovery-oriented care is based on the recognition that each person must be either the agent of or the central participant in his or her own recovery journey. All services and supports, therefore, need to be organized to support the person in this recovery process. It follows from this core value

Services should instill hope; be person- and family-centered; offer choice; elicit and honor each person's potential for growth; build on a person's/family's strengths and interests; and attend to the person's overall life, including health and wellness.

that services also should instill hope; be person- and family-centered; offer choice; elicit and honor each person's potential for growth; build on a person's/family's strengths and interests; and attend to the person's overall life, including health and wellness. These values can be the foundation for all services for people in recovery from mental illness and/or addiction, regardless of the service type (e.g., treatment, peer support, family education, etc.). There are many pathways to healing—both inside and outside of the formal health system—that people with mental illnesses and/or addictions can take in their recovery.

That said, what significant differences remain? Apart from the neurophysiology of these disorders, which remains to be determined, one important difference is in the role of behavior change. A useful model of behavioral change that has led to a popular approach to addiction treatment has been the Transtheoretical Model, proposed by Prochaska and DiClemente (1986). This is the model at the heart of motivational interventions that attempt to facilitate a person's movement along the continuum from precontemplative and contemplative to preparation and then action (leading eventually to maintenance). While this model, tailored to the person's stage of change, has been effective in promoting recovery in addiction, its use in relation to mental illness is not as straightforward. This is because the Transtheoretical Model of Change is a model of behavioral change, and the role of behavioral change in mental health is somewhat different from that in addiction.

A person can, and does, make many choices when living with and recovering from a mental illness, of course, but these choices are different from the choice to use or not to use substances. For people in recovery from a mental illness, choices include what they do *in response to* experiencing symptoms (e.g., do what the voices command or try to ignore them); what they do *to prevent or minimize* symptoms (e.g., find effective ways to manage stressful situations, take medication); and what they do *to manage or overcome* the disorder (e.g., learn self-care skills, reach out to others). The issue of choice in substance abuse disorders is a complex one without a

simple answer, but an argument can be made to support that idea that choice is an important factor in whether a person uses substances and whether a person stops using substances. A person with a mental illness seldom, if ever, has the choice of whether or not to have the illness, but does have the choice of how to respond.

But once stated this way, the primary role of behavioral change in addiction may need to be somewhat modulated by the variety of factors that also influence the onset and course of serious mental illnesses, factors that lie outside of the person's own sphere of influence, particularly when addictions and mental illness co-occur. These include social conditions, such as poverty, discrimination, and unemployment, as well as interpersonal and biological factors, such as the availability of social support and the responsiveness of symptoms to medications. As we learn more about the neurophysiology and social dimensions of addiction, we may eventually find that this is an area in which the addiction field can learn from mental health. The increasingly important role of recovery support services in addiction care—services, such as case management, that in the past were sometimes viewed as “enabling”—certainly suggests that just such a change is already beginning to take place.

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8. How is recovery relevant for inpatient units and/or psychiatric emergency departments?

The basic tenets of recovery-oriented practice of being hopeful, having respect for the dignity of each individual person, identifying and building on strengths, and looking beyond symptom reduction to a life in the community are equally relevant for all settings, including inpatient units and

Recovery-oriented practices in these settings embody the core elements of trauma-informed care, which include safety, trustworthiness, choice, collaboration, and empowerment.

psychiatric emergency departments. Rather than not being relevant to such acute care settings, one could argue that it is in these settings more than any others in which people in distress are in most need of hope-filled messages, most desperate for respect and dignity, and can use the most help in identifying and building on their own strengths. In addition, given the high prevalence of trauma in the lives of persons with serious mental illnesses and given that people with serious mental illness are often seen in emergency departments or inpatient settings (to which admission is also a traumatic event) as a result of or response to trauma, it is especially important that practitioners in such acute care settings be aware of and attentive to the histories of trauma most people will bring in with them. Recovery-oriented practices in these settings must therefore embody the core elements of trauma-informed care, which can include safety, trustworthiness, choice, collaboration, and empowerment.

This is not to say that it is easy in such settings to maintain a positive, strength-based, and empowering culture. It requires hard work to remain hopeful in the face of significant suffering, and exerted efforts to honor, respect, and show compassion for the individuality of each person when he or she may not be in control of his or her own behavior or speech. Practitioners, themselves, must be particularly attentive in these settings to their own self-care: having a supportive community of colleagues, opportunities to mitigate burn out, a place to express frustrations, disappointments, grief, and triumphs. Nonetheless, it is the staff's responsibility in hospital and acute care settings to maintain a safe and dignified milieu and to continue to treat each person respectfully as a unique individual. The addition of peer staff or consultants to such settings to serve as either advocates or companions, or to provide training to staff, has been found to contribute to the establishment and maintenance of such a respectful culture (O'Connell & Stein, 2005).

One major concern in these settings is that staff perceive there to be a conflict between the emphasis of recovery-oriented practice on self-determination and the frequent need in such settings for the staff to act in ways that the person has neither chosen nor agreed to, with involuntary commitment to a hospital setting being the prototypical example. This is a challenging question that requires ongoing discussion within these settings. Honoring self-determination, however, does not require, and is not equal to, doing whatever the person wants. Self-determination means that I have control over what I do, not over what you do. Mental health professionals are bound both by their professional ethics and by their societal obligation to act in the person's and community's best interests, even if that may be in conflict with the person's wishes at the time. When a person is incapacitated by an acute episode of psychosis, is unable to make his or her own decisions, and poses a serious and imminent risk, the recovery-oriented practitioner is equally obligated to intervene on the person's and the community's behalf.

There is no need to view such interventions as conflicting with a recovery orientation if you consider the parallels to emergency medicine: When a person is in a car accident or knocked unconscious by some other means (e.g., a fall, a sporting activity), it is incumbent upon the medical professionals present to intervene on the person's behalf prior to securing his or her consent to treatment. In an emergency of any type, medical professionals are taught to do whatever is necessary to save the person's life and to preserve his or her bodily integrity. We do not tend to view such emergency measures as "involuntary" or intrusive, but as necessary.

When a person is in a car accident or knocked unconscious, it is incumbent upon the medical professionals present to intervene on the person's behalf prior to securing his or her consent to treatment.

The same can be true in psychiatry if we conceptualize acute psychiatric distress as having a similar impact as a loss of consciousness or a heart attack. The reason that we do not ordinarily think of emergency psychiatric measures in this way is due to the unfortunate history of the field, in which such measures were taken in nonemergent situations and for people who were no longer in acute distress. When a person has recovered from a heart attack, she is released from hospital care. It has not always been given that a person would return home after an acute episode of psychosis. We must overcome this tragic legacy by limiting the use of involuntary practices to emergency situations and by refusing to accept the use of force or coercion as elements of standard practice.

Recovery-oriented practice in this way is not contradictory to emergency intervention on the person's and community's behalf. What recovery-oriented practice requires is that such interventions be performed respectfully, in ways that ensure the dignity of the individual, with transparency, only for as long as is required

by the emergent situation, and in ways that optimize the person's opportunities for exercising whatever degree of self-determination remains possible at the time. This typically requires the staff to offer the person choices, even though they may be limited to a narrow range, and to be as clear and explicit as possible with the person throughout the process about what is happening, why it is happening, and what needs to happen for the person to regain control and autonomy.

As noted above, recovery-oriented practice also requires the practitioner to take into account the likely presence of a trauma history, especially when restricting another person's liberty, in using seclusion or restraint, and in ensuring that the person feels safe. Planning ahead of time with the person how he or she might wish to have staff act, should he or she become temporarily incapacitated (either in the form of an advance directive or upon admission to an inpatient or crisis unit), sets a firm foundation for all of the above and ensures that the person is engaged as a partner in the process.

Advance directives can be an essential tool for people with mental illnesses to maintain self-determination and informed consent throughout their treatment experience, especially during times of incapacity (O'Connell & Stein, 2005; Scheyett et al., 2007; Swartz & Swanson, 2007). Informing and educating people about their

Advance directives can be an essential tool for people with mental illnesses to maintain self-determination during times of incapacity.

rights to create and execute advance directives with written and/or verbal instructions about their physical and psychiatric care can significantly decrease the need for involuntary practices, as people are engaged more effectively (Elbogen et al., 2007; O'Connell & Stein, 2005; Scheyett et al., 2007; Swartz & Swanson, 2007).

Finally, many recovery-oriented tools can be used in inpatient units and emergency departments. If the person is not already using Wellness Recovery Action Planning (Copeland, 1997), for example, then this self-care approach (or other similar ones) can be introduced to him or her during the acute episode. When the person already has such a plan, the plan should be respected and followed, including, for example, contacting the individuals listed in the plan as supporters. Person-centered care planning should be carried out in all mental health settings, and if the person already has such a plan for their work with other practitioners, then this plan should be honored and incorporated into the acute care setting as well.

For further reading:

Practice guidelines: Core elements for responding to mental health crises. HHS Pub. No. SMA-09-4427. Rockville, Md.: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009.

9. How is recovery relevant for a justice-involved client population?

The basic tenets of recovery-oriented practice of being hopeful, having respect for the dignity of each individual person, identifying and building on strengths, and looking beyond symptom reduction to a life in the community are equally relevant for all people with psychiatric disabilities, including those involved with the justice system. The difference for justice-involved clients is that there may be legal restrictions placed on them due to their alleged offense, and these restrictions will likely constrict the range of opportunities and choices open to them. Just as we find with acute care, however, this reality is not in conflict with recovery-oriented practice, but it does establish some parameters within which practice can take place. The first rule of thumb for the recovery-oriented practitioner in such circumstances is to be transparent and explicit about those parameters and educate the client, if needed, about the nature of his or her charges or conviction and the consequences that have been determined for him or her for the near future. It is within those parameters that the practitioner can then work with the person to encourage and facilitate his or her self-care and to promote a vision of the kind of life that will be possible for this person in the future.

Two critical factors that amplify the need for recovery-oriented care for people involved in the justice system include the level of social exclusion and trauma that a person experiences leading up to and as a result of convictions or incarcerations. Most of the people incarcerated will eventually be released back into the community and will then either lead productive lives or return to prison as a result of reoffending (Ducate, 2010). In these circumstances, it is especially important that recovery-oriented approaches recognize the impact of these experiences on a person as well as support him or her in re-authoring his or her personal narrative, moving from “offender” to community citizen as well as from “patienthood” to personhood.

It is important to support re-authoring a personal narrative, moving from “offender” to community citizen as well as from “patienthood” to personhood.

Another consideration in working with people with justice involvement is how practitioners view the issue of compliance. Assisting a person involved in the justice system to engage in recovery involves a very different process from assisting a person to comply with community supervision or court-ordered treatment. Often, it is very difficult for the person in recovery, much less for practitioners, to make the distinction of whether he or she is personally engaged or is complying with external pressures. As could be expected, the person who is personally engaged in his or her recovery will be more likely to sustain tenure in community roles and reduce or eliminate future involvement with the justice system. In contrast, the person who is

only complying with community supervision or court-ordered treatment may only realize the tenuousness of his or her hold on recovery when she or he is informed of being “off paper,” no longer being required to submit to toxicology screens or blood draws, or no longer being required to have supervision visits. This implies the need for more explicit dialogue with people about their level of engagement and an ability to choose shared markers for measuring progress in community integration efforts.

Regardless of personal engagement in the recovery process, offering recovery-oriented care remains essential. Additional, useful practices for ensuring a more successful and recovery-oriented re-entry experience for people involved with the justice system are proactive pre- and postrelease planning and support that include supported housing, treatment options, and education, employment, and peer support resources.

Useful practices for ensuring a more successful and recovery-oriented re-entry experience for people involved with the justice system are proactive pre- and postrelease planning and support that include supported housing, treatment options, and education, employment, and peer support resources.

For further reading:

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10. Is recovery different for people from different cultural backgrounds?

Yes, recovery is different for people from different cultural backgrounds (DHHS, 2001). Different cultures have different traditions of healing, spirituality, and seeking and receiving help for what practitioners consider to be mental health concerns. In addition, the notion of what is “normal” or what constitutes “the good life” also differs considerably from one culture to another, just as ideas of what constitutes “illness” differ (Stanhope et al., 2005; Yamada & Brekke, 2008). It is also important to note that “culture” is a broad term that can refer to characteristics of what makes people part of a group with which they identify: race or ethnicity, religion or spiritual beliefs, language, country of origin, sexual orientation or gender identity, disability status, socioeconomic status, educational background, trauma experience, and more.

For these reasons, it is essential for recovery-oriented practitioners to ask about, explore, and understand each person’s cultural

It is essential for recovery-oriented practitioners to ask about, explore, and understand each person’s cultural identity and affiliations as core aspects of what makes them who they are as people.

identity and affiliations as core aspects of what makes them who they are as people (Clay et al., 2005; Cuellar & Paniagua, 2000; Davidson et al., 2006a; Girard et al., 2006; Herman et al., 2007; Swartz & Shorter, 2007). There are important differences in the ways in which certain mental health interventions (including some medications) will be received by, and will or will not be effective for, people from different cultures. Since recovery has to do with the kind of life the person had prior to the illness and desires to lead in the future, as well as what treatments are effective for the illness he or she has, cultural differences become even more important in determining what a person's recovery will look like. There are multiple pathways to recovery, and culture is one of the factors that will determine which paths are most accessible to and useful for which people.

In addition to considering questions and approaches that help practitioners to explore and understand each person's cultural identity, there are a number of steps that can be taken to increase programmatic cultural competence. These include:

- Proactively adapting evidence-based practices to increase their cultural responsiveness, appeal, and effectiveness
- Maintaining a clinical and administrative staff that is culturally, ethnically, and linguistically diverse and that reflects the population served.
- Partnering with cultural communities as sources of referral, public trust, training, consultation, and engagement
- Attending carefully to first-contact and engagement approaches to ensure that cultural and linguistic priorities are elicited and honored and that people receive adequate orientation to the services and supports available
- Clarifying and communicating areas of programmatic flexibility for practitioners and clients
- Establishing and maintaining open pathways of communication between staff and clients about their histories, culture, needs, and desires, which sometimes means being willing to engage in discussions that have not traditionally been part of a therapeutic approach on subjects such as: religion, sex, race, etc..
- Adjusting individualized recovery-planning approaches to allow for the involvement (or noninvolvement) of family members and other culturally relevant partners
- Having discharge planning that identifies the cultural communities that a person and family may hope to re-engage as more permanent sources of support

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11. How is recovery relevant for children and youth? What does “resilience” mean? What does it mean for practices to be resiliency-oriented?*

Rather than trying to make the concept of recovery relevant for children and youth, youth and family advocates have made the case for a similar use of the concept of resilience (French et al., 2010). Unfortunately, there is no single accepted operational definition of “resilience,” and the term is used in different ways by different people—and this is only one of the many commonalities between the concepts of resilience and recovery. In general, though, we understand children and youth to show resilience when they can be flexible and adapt positively in the face of stress, when they are able to resist, withstand, cope with, rebound from, and grow—or even thrive—after experiencing life events that are stressful (French et al., 2010; Pugh & Lamb, 2010; Romano et al., 2010).

As applied to children and youth with serious emotional disturbances or the early stages of a mental illness, the concept of resilience generates implications for practice that are consistent with those generated by the concept of recovery. These include, but are not limited to, the following (Ridgway, 2004; Davidson, Rakfeldt, & Strauss, 2010; McKnight, 1992):

- Hope plays a crucial role in resilience and recovery.
- Resilience and recovery view the notion of a person being an active agent as central to improvement, and therefore give prominent attention to the person's sense of self, agency, and self-efficacy.
- Resilience and recovery involve self-direction.
- Resilience and recovery require clear resolve and commitment on the part of the person.
- Resilience and recovery involve active coping, competency building, and mastery.
- Resilience and recovery stress the roles of self-awareness, self-monitoring and self-regulation, and self-care.
- Resilience and recovery promote effective role functioning.
- Resilience and recovery are promoted through social support and the mobilization of both internal and external supports and strengths.
- Peer support, role models, and mentors can play useful roles in promoting resilience and recovery.
- Both require a positive structure and a safe environment. Environments can be either entrapping or enabling; therefore, resilience and recovery flourish within a safe and positively structured setting that is personally meaningful.

Resilience and recovery view the notion of a person being an active agent as central to improvement, and therefore give prominent attention to the person's sense of self, agency, and self-efficacy.

*The material for this section has been excerpted from a working paper drafted by Priscilla Ridgway for the Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services (HHS). The reference for this paper is Ridgway, P. (2004). Resilience and recovery from psychiatric disability: Links in concepts and research. L. Kan.: University of Kansas School of Social Welfare.

12. How can I instill hope in those with whom I work? What if people don't want care or don't have personal goals?

These questions are often raised by practitioners who are concerned that the people they work with have given up on whatever hopes, dreams, or aspirations they may

have had earlier in life or who have been met with a blank stare or a shrug when they have asked the question, “What goals do you have?” The process of identifying and setting personal goals provides the foundation for recovery planning, however. The question of whether or not people have such goals, therefore, is an important one to address. The following are issues to consider in assessing the situation in which a person appears not to have any hope or personal goals:

Has this person become demoralized over time, due to repetitive experiences of failures and losses that have been due to mental illness, or stigma and discrimination, or a combination of both? Has the person lost hope as a result?

It can be extremely difficult to have a mental illness, and extremely challenging to carry on one’s life in the face of it. It also may be hard to keep picking up the pieces time and time again when things fall apart, or to continue to believe that the future might be any better than a bleak or desperate present. The presence of a basic sense of hope is crucial to a person identifying any goals for the future. When hope has been lost, it can—and must—be restored as an essential basis for the person’s active engagement in recovery and for him or her to take an active role in identifying and pursuing personally meaningful goals.

When hope has been lost, it can—and must—be restored as an essential basis for the person’s active engagement in recovery.

The restoration of hope can come about in a variety of ways, including through the activation of spirituality and faith, experiences of pleasure, and supportive and inspiring social and professional relationships. When a person has lost hope or faith, it is crucial that practitioners and supportive others continue to carry hope for that person until a time that he or she can once again begin to believe that life can get better. Peer staff, who provide tangible and credible evidence of the possibility of recovery, can be especially effective in instilling hope through their core function as role models (Clay et al., 2005; Davidson et al., 2006a; Girard et al., 2006).

Has this person become socialized into a mental health system that has not cared about his or her aspirations or interests in the past? Is what you are seeing the result of “learned helplessness,” rather than a lack of goals? Or might the person be so impoverished that he or she does not have the means to pursue goals?

If a person has for years been receiving services that have not been tied to any personal desires or wishes, it might be difficult for him or her to believe that a mental health practitioner all of a sudden wants to know about such things as his or her goals. The person may first need to come to see that services have changed and

that people are now more interested in him or her as a person who is more than his or her diagnosis, problems, symptoms, or deficits.

In addition, it is difficult to pursue many interests without disposable income or without accessible transportation. The person may be more stymied by a lack of resources than by a lack of interest. In this case, the person may need assistance identifying activities and events he or she can participate in without additional resources, or there may be ways to produce the additional resources needed through scholarship or community programs.

It is possible that through the combination of socialization to what are seen as the traditional limits for people with mental illness and the lack of means to pursue their interests, people may lose any sense of what they might find interesting or enjoyable. In this case, helping the person to get back in touch with what interested him or her, or what he or she enjoyed, prior to becoming ill may be a useful place to begin the process of re-igniting or jumpstarting his or her passion. There also is an array of tools, including interests and strengths assessments, that might help the person to recall those things that he or she had found pleasurable or meaningful in the past (e.g., O'Brien, 1987; Saleeby, 2001).

Finally, there can be no substitute for actual life experience in re-

There can be no substitute for actual life experience in re-igniting or eliciting a person's interest.

igniting or eliciting a person's interest. For some people, simply talking about participating in an activity is just as likely to raise anxiety and introduce doubts as it is to whet his or her appetite for involvement. Especially for people who have become accustomed to viewing life as if from a distance, as something that happens primarily to other people, it may require both encouraging and accompanying the person for him or her to feel comfortable trying new things. In one horseback riding program, for instance, it wasn't until a person was actually helped to climb onto a real horse that he realized that he was not merely going to discuss horseback riding or watch other people ride horses, as he had become accustomed to doing at the psychosocial club to which he belonged for many years.

Has this person become afraid of taking risks, either because he or she might fail or be perceived as failing by others, or because success or failure might precipitate a relapse or setback?

For a person to try new things, he or she must have some sense of confidence in his or her own abilities to succeed. Repetitive frustrations and losses can drain people of any sense of confidence, making risk-taking even more difficult than usual. In the case of someone with a prolonged mental illness, taking risks also poses potential difficulties in addition to not succeeding if they have been repeatedly told that their

risks are trivial, stupid, harmful, worthless, dangerous, and more. Failures can precipitate relapses or setbacks. So, at times, can successes. For a person who has become resigned to a limited, if relatively safe life, trying new activities may also require him or her to face additional challenges and demands. Such challenges and demands can then increase the person's anxiety or worries about the future. It may be necessary in addressing these kinds of concerns to begin with concrete, incremental, and everyday goals such as getting out of the apartment or seeing a movie with a friend.

Could this person have a co-occurring depression?

In the past, mental illnesses were thought to be mutually exclusive. For example, it was assumed that a person who had schizophrenia could not also have an affective disorder such as depression. Recent research, however, has shown that it can indeed be depressing to have a mental illness, and that psychotic disorders and depression co-occur very often in the same person (Swartz & Shorter, 2007). It therefore is important to assess people who have serious mental illnesses for the presence of depression in addition to any other illness they may be experiencing. The loss of hope seen in some people who say that they do not have any personal goals may be just as suggestive of depression as of negative symptoms. It is important to assess for and to offer effective treatments for depression when present.

Have you taken the time and made the effort to earn this person's trust so that he or she would feel comfortable enough to share such personal information with you?

For many people, especially those who have had bad experiences with behavioral health care in the past, trust

Trust in healthcare providers has to be earned. It should not simply be assumed.

in healthcare providers has to be earned. It should not simply be assumed. It is reasonable, therefore, to wonder whether this person has no goals or, rather, that he or she may not feel comfortable formulating and sharing those goals with a relative stranger. In such situations, it may take an extended period of time to develop a trusting relationship (or therapeutic alliance) that enables the person to feel comfortable doing so. To develop such trust, it may be essential to start where the person is at (i.e., not feeling comfortable talking about personal goals) rather than where the provider wants the person to be (i.e., specifying a list of goals for completion of a care plan). As one woman who had been assigned to an assertive community treatment team, and who had refused the staff's initial efforts to engage her in activities, quipped: "There they were, running around making all these plans for me, and they had no idea who I was."

The rich tradition of psychotherapy offers many useful tools for "joining with" the person under these circumstances (e.g., Ackerman & Hilsenroth, 2003; Raue,

Goldfried, & Barkham, 1997; Zafran & Muran, 2003). Peer staff may be especially effective in such circumstances, as they have demonstrated an ability to more rapidly engage people into trusting relationships based both on their own history and on the enhanced credibility this history gives them in the eyes of others (Davidson et al., 2005; Davidson et al., 2006b). In addition to establishing trust, peer staff also can be especially effective, as they can not only offer to accompany the person in trying new activities, but can also offer a hope-instilling role model that recovery, and a richer life, is indeed possible.

Is this person experiencing signs or symptoms of a mental illness that might pose barriers to his or her participation in interesting or enjoyable activities?

Some of the more disabling aspects of mental illness are also some of its more invisible aspects, such as neuro-cognitive impairments and communication difficulties (Davidson & McGlashan, 2005). When these aspects of illness interfere with participation in social, recreational, educational, or vocational pursuits, the person may be reluctant to identify any goals, for fear of not being able to perform well in such situations.

Some of the more disabling aspects of mental illness are also some of its more invisible aspects.

Identifying, assessing, remediating (when possible), and accommodating (when remediation is not possible) symptoms, impairments, or fears that pose barriers to relationships and active participation in social activities may be an important first step to facilitating greater involvement. Identifying such barriers also may help practitioners to suggest activities or pursuits that are well-matched to a person's interests but do not require capacities he or she may not have at the time. Social activities that do not require much verbal interaction, such as gardening, fishing, or attending music performances, for example, may be especially appealing to people who worry that they will not be able to carry on conversations for extended periods.

The following vignette captures some of these aspects of living with a serious mental illness that might make identifying and pursuing personal goals difficult. We have been impressed with the power that persistence, patience, and gentle encouragement can exert in enabling practitioners to connect to the person who may have been buried behind or underneath an illness and the secondary effects of institutionalization, discrimination, poverty, unemployment, and isolation.

We were impressed, for example, by a 38-year-old man who had had a psychotic disorder for 20 years and who had lived almost exclusively in his bedroom in his mother's home for the duration of that period. He was occasionally hospitalized when he became incommunicative and stopped eating, but otherwise spent his days

almost entirely alone, smoking in his room, except for brief, sporadic encounters with family members. We encountered him during one of his hospital stays, and spent a week trying to talk with him and determine his reasons for not eating and no longer talking with his family. He was reticent to talk with us or any of the other staff, sat silently through group meetings, and ignored his family when they came to visit. He appeared to be taking no advantage of the hospital stay (except for minimal eating and drinking), and both the staff and family felt stuck. He appeared not to want anything, voiced no complaints or dissatisfaction, and refused to participate in care or discharge planning.

This scenario continued until a family meeting was facilitated with the presumptive agenda of discharge planning. There appeared to be no reason to keep this man in the hospital any longer, but his family was concerned that he was only minimally better than when admitted and did not want to take him back, only for him to resume his earlier behavior. The family reassured him that they wanted to take him back home, but expressed their concerns that he no longer ate meals and no longer even spoke to them, worrying that he was “wasting away” before their eyes. When we first asked the young man if he was aware of these changes in his behavior, and, if so, if he had any ideas about what might have happened, he did not respond. We then asked the young man if he felt ready to return home under these circumstances, to which he again did not respond.

After a brief and awkward silence, he was then asked if he felt that perhaps this

Was he resigned to spending the rest of his life alone in his bedroom? He simply said, “No.”

was all that life had to offer him. Was he resigned to spending the rest of his life alone in his bedroom? At this point, tears started to well up in his eyes and slide down his cheeks. After another brief silence, he simply said, “No.” After waiting for a further response (which did not come), we then responded, “I’m glad. That would have been really awful. What else **would** you like to do?” It was then that he begrudgingly explained that he had felt that his family had “given up” on him. His perception was that they had gradually invited him to fewer and fewer activities and events, had gradually sought him out less frequently, and had begun to leave him out, and leave him behind, as they went on with their own lives. His further withdrawal and refusal to eat was both a test of their abandonment (would they simply let him die, like the bug in Kafka’s “Metamorphosis”?) and a sign that their giving up on him had led him to give up on himself. He was hurt and angry that, despite his many refusals, they had not continued to pursue him.

Rather than responding to what the family might have viewed as obstinence, the man’s mother was overwhelmed by his expression of affect (something she said she had not seen for 20 years) and readily understood his concerns about her preoccupation with other family matters, the decreased availability of his siblings

(who now had families of their own), and how these changes in the family had affected him. We suggested that the family’s insistence on bringing him to the hospital, and their continued concern with his “wasting away,” was “proof” that they would not simply allow him to die alone, and suggested that they could discuss some of the ways in which he could be included in family activities and events.

This one meeting did not, of course, bring about a significant shift in his pattern of withdrawal and isolation, or in the difficulties the family would face in trying to include him more in family life, but it did serve to establish an important lesson for the involved parties. As much difficulty as this man had in participating in family relationships, activities, and events, it was not to his benefit for the family to passively accept his withdrawal or to contribute to his further marginalization. An important challenge for this person and his mother, and the mental health practitioners working with them, became how they could build bridges for him back into that world. In this case, person-centered care planning began with the goal of increasing the person’s contact with family members, with one measurable objective being that he and his mother would have several meals together each week (instead of him taking all of his meals alone in his bedroom). To some, this may appear to be a small step forward, but it represents the beginning of his recovery journey nonetheless. And for this young man, this may have felt like a very big step indeed.

As this story suggests, many attempts can be made to encourage and support people in identifying personal goals. These include restoring or building hope; developing a therapeutic alliance; adopting a person-centered and strength-based approach; appreciating the value, dignity, and potential fears involved in taking risks; treating underlying depression; addressing skill or neuro–cognitive impairments; and expanding access to opportunities for a person to explore his or her interests and to participate in meaningful and/or pleasurable activities.

Most people do not live their lives in terms of “goals.” It may be useful for the practitioner to assist the person in the process of identifying interests, desires, or aspirations.

A final consideration is that most people do not live their lives in terms of “goals” at all, and discussions of such

goals may at first strike some people as a foreign or artificial exercise. In this case, in addition to the strategies recommended above, it may be useful for the practitioner to assist the person in the process of identifying interests, desires, or aspirations, and then breaking these down into incremental steps that can be formulated as short-term “goals.” This is a process for which the discipline of psychiatric rehabilitation has developed valuable tools (e.g., Anthony et al., 2002).

For further reading:

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13. What role do medications play in recovery?

Medications can be an effective tool in a person's recovery if they reduce, contain, or ameliorate the symptoms of the illness (Deegan, 2010; Falloon et al., 1998; Falloon et al., 1998; Noordsy et al., 2000; Weiden et al., 2007). Many people for whom medication has been effective in this way consider it crucial to their recovery; for some, it has even been life-saving (Deegan & Drake, 2006a; Deegan, 2007).

For most people with serious mental illnesses, however, medication alone is not sufficient to achieve recovery. It is no silver bullet for "fixing" mental illness. One reason is because existing medications typically address only some of the symptoms of serious mental illness (e.g., hallucinations and delusions), and these are not the most disabling aspects of the illness. Medications have not yet been found to address neuro-cognitive impairments or negative symptoms (Iancu et al., 2010; Novick et al., 2009).

In addition, there remains much work to be done in rebuilding one's life, even when the medications work effectively and the person derives full benefit from them. As Bill Anthony has quipped, "The medications can help to reduce my symptoms, but they can't teach me how to play the piano." Essentially, the work of rebuilding one's life following the onset of a serious mental illness can be significantly facilitated by the effective use of medication, but cannot be achieved through medication alone.

Finally, it is important to recognize that existing medications are only effective for about 70 percent of people diagnosed with a serious mental illness, leaving 30 percent who will derive little, if any, benefit from taking it (Brown et al., 2010; Stroup & M., 2003). For these people, the onerousness and potential danger of the side effects of certain medications may lead a person to choose not to take them at all. In fact, a significant percentage of the 25-year discrepancy in life span for those with and without a serious mental illness is accounted for by the side effects of some of these medications (Casey & Hansen, 2009; Goff et al., 2005). Practitioners need to be knowledgeable about these side effects and to be experienced in

weighing the potential pros and cons, or costs and benefits, of a given medication when recommending its use.

Perhaps most importantly, it is a cornerstone of recovery-oriented practice that the decision to take medication is viewed and treated precisely as that, a deeply personal and important decision that the person will have to make for him or herself, in consultation with loved ones and knowledgeable mental health practitioners.

The decision to take medication is viewed and treated as a deeply personal and important decision that the person will have to make for him or herself.

For further reading:

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14. How can consumers self-direct their treatment and their lives if they have a mental illness?

This question cuts to the core of the assumptions that the recovery movement calls into question. Having a mental illness does not necessarily impair a person’s judgment (Strauss & Carpenter, 1977). We have been mistaken to think that a mental illness takes over the entirety of the person’s life and compromises all of the

person's faculties. This belief is simply not supported by the data (Strauss & Carpenter, 1982). Rather, people with serious mental illnesses retain their rights, by law, to self-determination, both in their treatment and their lives, until, unless, and then only for as long as, they might be temporarily incapacitated by the illness. Even for people whose illnesses are so severe as to cause such temporary periods of incapacitation, these periods are typically occasional and short-lived, with the remainder of the person's life lived in nonacute states of enhanced functioning.

There also is no relationship between mental illness and a lack of intelligence (e.g., Nobel Prize-winning mathematician John Nash, who lives with schizophrenia) or a lack of maturity (e.g., Patricia Deegan and Elyn Sacks, both of whom have been diagnosed with schizophrenia and demonstrate a degree of emotional maturity that is hard to find anywhere). This is a little like assuming people who don't have a mental illness are always intelligent, mature, and make good decisions. The data, again, does not support that; people without mental illness also struggle to make good decisions and to lead emotionally mature lives. Therefore, the assumption that people with mental illness cannot make their own decisions because they are either unintelligent or immature, or based solely on their diagnosis is false and discriminatory, and is not abided in a recovery-oriented system of care.

This is not to suggest that people with mental illnesses always make the "right" decisions (however that is defined) or make the choices practitioners would like for them to make. But it is again important to acknowledge that people who do *not* have mental illnesses also do not always make the "right" decisions or the decisions that other people want them to make. Unless and until they are incapacitated by the illness, people with mental illnesses have the same rights to make their own mistakes as anyone else. They also appear to have the same capacity to learn from those mistakes as anyone else.

In rare circumstances, there will be people, of course, who do demonstrate what we ordinarily refer to as "poor judgment," who appear not to learn from their mistakes, and whose decisions place them at certain kinds of risk, e.g., of self-harm or victimization. In such cases, it is important to consider that these difficulties are not due solely to the mental illness, but also may be the result of other life experiences or medical conditions, including traumatic brain injury or experiences of trauma, among others.

Finally, it is important to appreciate the fact that people can only become better decision-makers by actually making decisions. One factor that often contributes to people appearing to have poor judgment is the fact that decisions have been made **for them** for extended periods of time, and they have come to doubt their own abilities to make decisions or to assume that they have none. Like muscles that are not used, a person's capacity to make decisions can atrophy or at least become rusty through lack of use. In such cases, people need incrementally to relearn to think

carefully and clearly about their options and opportunities, to weigh the possible outcomes of their decisions, and to gain confidence in their ability to make and follow through with decisions that are effective in getting them where they want to go (Deegan, 1996). Through this process, they gradually take back control of their lives and their decisions, building on small successes until their confidence in making the right decisions for themselves has been restored.

For further reading:

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- Scheyett, A.M.; Kim, M.M.; Swanson, J.W.; & Swartz, M.S. (2007). Psychiatric advance directives: A tool for consumer empowerment and recovery. *Psychiatric Rehabilitation Journal*, 31(1), 70–75.

15. Do you really believe that people with serious mental illnesses should be trusted to make their own decisions?

Yes. How else will they learn from experience? Patricia Deegan talks about “dignity of risk” as an important component of the recovery process (Deegan, 1996; Deegan & Drake, 2006b). In truth, this is an important component of *everyone’s* development. And, as mentioned above, it is not for the practitioner to determine a person’s trustworthiness (or lack thereof) to make his or her own decisions. People do not lose their civil rights and their rights to autonomy after diagnosis of a serious mental illness any more than they lose those rights when they’re diagnosed with diabetes or asthma. The person has, and retains, the right to make those decisions, unless, until, and then only for as long as, he or she poses a serious, imminent risk to self or others, or has proven to be incapable of taking care of him or herself (as determined by a judge).

Often, practitioners are concerned about the risks of people with schizophrenia forgoing treatment, discontinuing medication regimens, choosing the safest place to live, or making choices about with whom they have a sexual relationship. In truth, research shows that very few of us make the “right” decisions all of the time; few of us are compliant with treatment regimens and few of us always choose the next step in our lives with accuracy. Within the long-term context of a person’s life, such instances of losing the right to make decisions should be infrequent, if they even happen at all.

16. Why is work an important component of recovery?

Work is an important component of recovery because work, at least in American society at the beginning of the 21st Century, is an important component of our lives and in our standing or value in society (Krupa, 2004; Marwaha & Johnson, 2004). Work has the same benefits for people with serious mental illnesses that it has for everyone else, and we have no reason to believe that those benefits will be any less important to someone just because he or she has a mental illness. In fact, work may become an even more important source of self-worth and identity for someone who has lost so many other sources and resources through the illness (Bush et al., 2009; Krupa, 2004).

In addition to promoting confidence and self-worth—and increasing a person’s income—work provides meaningful structure to a person’s day and week, exercises his or her mental faculties, introduces him or her to new potential friends, and provides a value social role. Surveys have consistently found that 70 percent of adults with mental illnesses would like to work, while the employment rate among this population remains around 15 percent. Supported employment studies have found a 65 percent success rate in assisting people with mental illness to obtain competitive employment, demonstrating that the gap between those who wish to work and those who can work can be closed through the provision of community-based supports (Burns et al., 2009; Dixon et al., 2010)

Work has further been shown to decrease symptoms, while prolonged unemployment has been shown to increase symptoms (Burns et al., 2009). Recovery-oriented practice thus reverses the current practice of preferring unemployment to the person engaging in stressful activity (i.e., work) and thereby risking relapse, understanding that prolonged unemployment and poverty pose more stress than taking a job (Dixon et al., 2010; O'Brien, undated). Recovery-oriented practice also reverses the conventional wisdom of suggesting that people become less symptomatic first before trying to return to work, based on the knowledge that work reduces symptoms, while sustained unemployment and inactivity do not.

Prolonged unemployment and poverty pose more stress than taking a job.

For further reading:

Becker, D., & Drake, R.E. (2003). *A working life for people with severe mental illness*. New York, N.Y.: Oxford University Press.

Burns, T.; Catty, J.; White, S.; Becker, T.; Koletsis, M.; Fioritti, A.; Rössler, W.; Tomov, T.; Van Busschbach, J.; Wiersma, D.; & Lauber, C. (2009). The impact of supported employment and working on clinical and social functioning: Results of

- an international study of individual placement and support. *Schizophrenia Bulletin*, 35(5), 949–58.
- Bush, P.W.; Drake, R.E.; Xie, H.; McHugo, G.J.; & Haslett, W.R. (2009). The long-term impact of employment on mental health service use and costs for persons with severe mental illness. *Psychiatric Services*, 60(8), 1024–31.
- Dixon, L.B.; Dickerson, F.; Bellack, A.S.; Bennett, M.; Dickinson, D.; Goldberg, R.W.; Lehman, A.; Tenhula, W.N.; Calmes, C.; Pasillas, R.M.; Peer, J.; & Kreyenbuhl, J. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia Bulletin*, 36(1), 48–70.
- Drake, R.E.; Becker, D.R.; Clark, R.E.; & Mueser, K.T. (1999). Research on the individual placement and support model of supported employment. *Psychiatric Quarterly*, 70(4), 289–301.
- Krupa, T. (2004). Employment, recovery, and schizophrenia: Integrating health and disorder at work. *Psychiatric Rehabilitation Journal*, 28(1), 8–15.
- Leff, J., & Warner, R. (2006). *Social inclusion of people with mental illness*. Cambridge, England: Cambridge University Press.
- Marwaha, S., & Johnson, S. (2004). Schizophrenia and employment: A review. *Social Psychiatry and Psychiatric Epidemiology*, 39(5), 337–49.
- O'Brien, D.; Ford, L.; & Malloy, J.M. (2005). Person-centered funding: Using vouchers and personal budgets to support recovery and employment for people with psychiatric disabilities. *Journal of Vocational Rehabilitation*, 23(2), 71–79.

17. Many people living with psychiatric illness are often concerned about losing their benefits if they return to work. How can you address these concerns?

First, it's important to acknowledge that this has been and is a viable concern for many people. Work is an integral component to many people's recovery, but the health care and substantive benefits they receive, and the financial and emotional stability those benefits provide, are precious and often hard-won. Fortunately, as the healthcare and entitlement systems in the country are being reformed, many programs already exist (e.g., Ticket to Work, PASS accounts) that enable people to return to work gradually without endangering their disability benefits and security. People need to be educated about these programs and get individual counseling from a benefits counselor to figure out what path is best for them. Secondly, people can start slowly and protect their benefits through education or vocational training or volunteer or part-time work prior to taking a bigger and more risky step. As the current healthcare reform process progresses and more people gain access to health care regardless of employment status, it is hoped that it will become much easier for people to pursue employment without having to worry about the loss of essential benefits.

18. What role does trauma play in recovery?

Research indicates that trauma plays a significant role in the lives of people with serious mental illnesses, both in the development of mental health problems and in the retraumatization experienced by many once they have mental health problems (Bernard et al., 2009; Lysaker, Outcalt, & Ringer, 2010). The impact of trauma remains underappreciated by many practitioners. Some estimates suggest that as many as 50 percent to 80 percent of people with serious mental illnesses have a history of early trauma prior to the onset of the illness (as reported in: Bernard et al., 2009; Lommen & Restifo, 2009; Manning & Stickley, 2009). By the time a person is given a diagnosis of a serious mental illness, that number reaches almost 100 percent (Lommen & Restifo, 2009).

Additionally, people with serious mental illness are significantly more likely to be victimized in various ways than those without mental illness (Fitzgerald et al., 2005; Honkonen et al., 2004). The intrusive and disruptive experiences of the illness itself are traumatic, and these experiences are further compounded by people's experiences of seeking help in a society that still suggests that people who have mental illnesses are fundamentally different from, and inferior to, others.

Trauma-informed care must be an integral part of any recovery-oriented care; to disregard the impact of trauma on the life of someone with serious mental illness is to ignore a significant cause of distress and an opportunity for recovery (Fuller, 2010; Lommen & Restifo, 2009). Some of the symptoms that we think of as being related to mental illness are in fact reactions to significant trauma (Harrison & Fowler, 2004; Lysaker & LaRocco, 2008). Those symptoms will not be improved until the trauma is effectively addressed; unidentified traumatic life experiences interfere with a person's ability to trust and to develop healthy relationships, which can provide key supports for recovery. Unidentified traumatic life experiences also often lead to choices that are not conducive to recovery, such as promiscuity, substance abuse, self-harm (e.g., cutting), and other issues.

For these reasons, recovery-oriented practice needs to be sensitive to the presence of trauma and offer the person opportunities and supports to deal with, and work through, his or her traumatic experiences in a safe setting, with trusted others (practitioners as well as peers). Practitioners are in this way encouraged to adopt the "universal precautions" of assuming that everyone they serve has had experiences of trauma, whether or not each person will be aware of or interested in exploring the impact that these experiences may have had. While a thorough review of trauma-informed care is beyond the scope of this discussion, we direct you to some additional resources below.

Practitioners are encouraged to adopt the "universal precautions" of assuming that everyone they serve has had experiences of trauma.

For further reading:

- Fuller, P.R. (2010). Applications of trauma treatment for schizophrenia. *Journal of Aggression, Maltreatment & Trauma, 19*(4), 450–63.
- Goodman, L.A.; Salyers, M.P.; Mueser, K.T.; Rosenberg, S.D.; Swartz, M.; Essock, S.M.; Osher, F.C.; Butterfield, M.I.; & Swanson, J. (2001). Recent victimization in women and men with severe mental illness: Prevalence and correlates. *Journal of Traumatic Stress, 14*(4), 615–32.
- Lommen, M.J.J., & Restifo, K. (2009). Trauma and posttraumatic stress disorder (PTSD) in patients with schizophrenia or schizoaffective disorder. *Community Mental Health Journal, 45*(6), 485–96.
- Lysaker, P.H.; Outcalt, S.D.; & Ringer, J.M. (2010). Clinical and psychosocial significance of trauma history in schizophrenia spectrum disorders. *Expert Review of Neurotherapeutics, 10*(7), 1143–51.
- Norsworthy, K.L. (2009). Mosaics of trauma and recovery: A feminist guide. *Psychology of Women Quarterly, 33*(2), 251–52.
- Padgett, D.K.; Hawkins, R.L.; Abrams, C.; & Davis, A. (2006). In their own words: Trauma and substance abuse in the lives of formerly homeless women with serious mental illness. *American Journal of Orthopsychiatry, 76*(4), 461–67.
- Van der Kolk, B.A. (2007). *The developmental impact of childhood trauma*. New York, N.Y.: Cambridge University Press.

19. What role does spirituality play in recovery?

We are just beginning to understand the important role that spirituality plays in recovery for many people, whether or not they identify with a specific organized religion or belong to a faith community (Fallot, 2001; Fallot, Mueser, & Jeste, 2008). As in 12-step movements, spirituality is often credited with helping people turn to recovery from a demoralized, despairing, and seemingly hopeless situation (Fallot, 2001; Green et al., 2003). People take comfort in the sense that there is a power or guiding force “out there” much greater than themselves and with which they can have a relationship, with or without a mental illness.

In addition to being a potential source of hope, strength, and self-worth, a person’s connection to a sense of spirituality represents an important dimension for recovery-oriented assessment and possibly for intervention (e.g., supported spirituality) when needed and desired by the person. Spirituality or religion can also be a tremendous resource for healing by providing a supportive community, opportunity for work and worth, and a source of hope for people who have lost other sources of hope (e.g., family, friends). Spirituality and religion can offer a person a sense of their history and culture prior to their mental illness and a sense of identity and vocation beyond that illness.

For further reading:

- Fallot, R.D. (2001). The place of spirituality and religion in mental health services. In H. R. Lamb (Ed.), *Best of new directions for mental health services, 1979–2001*. San Francisco, Calif.: Jossey-Bass, 79–88.
- Fallot, R.D.; Mueser, K.T.; & Jeste, D.V. (2008). Spirituality and religion. In *Clinical handbook of schizophrenia*. New York, N.Y.: Guilford Press, 592–603.
- Keks, N., & D'Souza, R. (2003). Spirituality and psychosis. *Australasian Psychiatry*, 11(2), 170–71.

20. What roles do the body and physical well-being play in recovery?

The causes of mental illness are still unknown, but the body clearly plays an integral role in recovery, as the mind and body are not separable. The Surgeon General's Report (DHHS, 1999) and the Consensus Statement on Mental Health Recovery from SAMHSA (SAMHSA, 2006) explicitly state the need for a comprehensive and holistic view of health that includes both mental and physical health. Just as there can be no health without mental health, there can be no mental health without physical health. Recovery-oriented practice therefore addresses the person as a whole, including both mental and physical health and the many ways in which they influence each other.

On the positive side, there are things people can do to enhance their physical health that simultaneously will enhance their mental health. For example, exercise helps to significantly reduce depression (Brosse et al., 2002; Hays, 1999) and improve people's sense of self-efficacy and agency (Gretchen-Doorly et al., 2009). Exercise and a healthy diet might also mitigate some of the difficult physical side effects of psychotropic medication, such as weight gain and diabetes. Acupuncture, massage, yoga, and other nontraditional physical therapies have also demonstrated a promising effect on mental illness symptoms (Russinova, Wewiorski, & Cash, 2002). More research needs to be done to investigate the link between physical health-promoting behaviors and recovery from psychiatric disorders.

Unfortunately, there also is a negative side to the relationship between mental and physical health, as many of the factors and situations associated with serious mental illnesses negatively impact the person's physical health as well. Poverty, social isolation, poor nutrition, and the side effects of certain medications pose considerable risks to a person's physical health. This is compounded by the lack of access for impoverished people with few financial or transportation resources to safe and easily available places to exercise and access to high-quality, healthy, low-cost foods. In addition, due to discrimination and a lack of mental health expertise in emergency and primary care settings, many people with serious mental illnesses receive poor-quality medical care, if they receive any medical care at all. As a result of these, and other (e.g., suicide, substance abuse), factors, people with serious

mental illnesses currently die on average 25 years earlier than people who do not have a serious mental illness (Brown et al., 2010; Casey & Hansen, 2009; Goff et al., 2005). As it is impossible to recover once you are dead, this alarming and pressing health disparity has become a major area of focus for recovery-oriented practice.

For further reading:

- Brown, S.; Kim, M.; Mitchell, C.; & Inskip, H. (2010). Twenty-five year mortality of a community cohort with schizophrenia. *British Journal of Psychiatry*, 196(2), 116–21.
- Casey, D.E., & Hansen, T.E. (2009). Excessive mortality and morbidity associated with schizophrenia. In H. A. Nasrallah (Ed.), *Medical illness and schizophrenia* (2nd ed.). Arlington, Va.: American Psychiatric Publishing, Inc., 17–35.

21. What is peer support?

22. Who provides peer support?

Peer support involves one or more persons who have a history of mental illness and who have experienced significant improvements in their psychiatric condition offering services and/or supports to other people with serious mental illness who are not as far along in their own recovery process or who are experiencing a setback or crisis (Davidson et al., 2005; Davidson et al., 2006a; Sledge et al., 2008). While there are differences of opinion about whether peer services embody mutuality, as is found in mutual support groups, or is more of a helper–helpee relationship, as in conventional health services, what is clear and important about peer services is the recognition that both the peer provider and the person he or she is reaching out to have been in the same boat and have the potential view each other as equals.

Both the peer provider and the person he or she is reaching out to have been in the same boat and view each other as equals.

Long before the development of the current models of peer support, peer support in mental health took the form of hiring recovering patients as hospital staff in the 1790s that enabled moral treatment to take hold at the birth of psychiatry at the end of the 18th Century (Davidson et al., 2010). Similarly, Harry Stack Sullivan, one of the most influential American psychiatrists during the first half of the 20th Century, hired recovered patients to staff his inpatient psychiatric service. Since then, self-help/mutual support approaches have been developed by and for people facing a diverse range of serious adverse conditions and events such as cancer or bereavement. The most common examples for alcohol and substance use disorders would be Alcoholics Anonymous and Narcotics Anonymous, as well as family peer support groups such as Al-Anon and Alateen.

While similar mutual support resources were developed by and for people with serious mental illnesses as early as the 1970s, it was not until the 1990s that mental health systems began once again to experiment with the strategy of hiring people in recovery to staff mental health programs (Davidson et al., 2010). In the nearly 200 years since people in recovery were initially hired as hospital staff, the value of peer support was largely eclipsed by the harsh realities of institutionalization, pessimistic prognoses, and discrimination against people with mental illnesses. Currently, an important aspect of the transformation of mental health and substance use disorder treatment involves recognizing people in recovery as capable individuals who have much to offer their communities, and who often want to give back (Davidson et al., 2005; Davidson et al., 2006a).

There is a long and distinguished history of people in recovery giving back in precisely these and other ways, some of whom are highlighted in the resources below. Contributions have been made through the aforementioned self-help/mutual support groups and consumer-run programs, and through the same rich variety of ways that others contribute to their communities (e.g., as volunteers, community organizers, elected officials, role models). Peer support is simply a relatively recent addition to this long history of valued social roles that can be occupied by people in recovery. It appears, however, to have certain unique features that make peer staff a most important addition to mental health programs.

The unique contributions of peer support appear to fall into three basic categories:

- Peer providers promote **hope** through positive self-disclosure, demonstrating to service users that it is possible to recover.
- Expanding on this **role modeling** function, peer providers teach self-care and illness-management approaches, and explore with people new ways of acquiring and using experiential knowledge, or “street smarts.” This knowledge is vital in negotiating day-to-day life, not only with the illness but also with the social and human service systems, with poverty, with unstable housing, and with overcoming discrimination and other trauma.
- Peer providers are able to engage others effectively into valued and valuable relationships. These relationships are characterized by a combination of **trust, respect, acceptance, and encouragement**. Peer providers listen attentively and nonjudgmentally to the aspirations and needs of the people they work with and assist them concretely in pursuing their aspirations and meeting their needs.

Peer providers are able to engage others effectively into valued and valuable relationships characterized by a combination of trust, respect, acceptance, and encouragement.

- Peer providers connect people to needed resources and help them identify barriers and possible solutions in a strength-based fashion.
- Because they have been in similar shoes themselves earlier in their lives, peer providers display empathy and patience, knowing how difficult it can be to accomplish the most trivial of tasks when beset by illness or demoralized by repeated losses and failures. They additionally encourage the consumers they work with to take action in pursuit of their dreams.
- As a result of their own life experience, peer providers often have much confidence in the strengths and capabilities of those they serve. They know that it is possible to recover, but also that it takes hard work to do so (e.g., “I know how you feel now, but I also know that you can have a better life”).

Hiring of people in recovery is an essential component as models of the effectiveness of treatment and that people can and do recover; this is valuable to people in recovery, to the peers, and to the clinical environment. Individuals in recovery are role-models for and provide support and understanding to others in need through their personal experiences at a time when individuals feel very lost and alone. The value of this role has been recognized by the Centers for Medicare and Medicaid Services, which provides reimbursement for peer support in an increasing number of states across the country (O'Brien, Ford, & Malloy, 2005). The unique power of the peer provider–service user partnership lies in their shared experiences, which can lead quickly to the establishment of a trusting relationship. On this foundation, the role of the peer provider can be seen as that of a trusted guide who has gone a few steps ahead on the recovery journey and returns to offer inspiration, guidance, encouragement, insight, and support to others.

For further reading:

- Carlson, L.S.; Rapp, C.A.; & McDiarmid, D. (2001). Hiring consumer–providers: Barriers and alternative solutions. *Community Mental Health Journal, 37*(3), 199–213.
- Chinman, M.; Hamilton, A.; Butler, B.; Knight, E.; Murrar, S.; & Young, A. (2008). *Mental health consumer providers: A guide for clinical staff. A RAND Health Technical Report.*
- Chinman, M.; Shoai, R.; & Cohen, A. (2010). Using organizational change strategies to guide peer support technician implementation in the veterans administration. *Psychiatric Rehabilitation Journal, 33*(4), 269–277.
- Chinman, M.J.; Young, A.S.; Hassell, J.; & Davidson, L. (2006). Toward the implementation of mental health consumer provider services. *Journal of Behavioral Health Services and Research, 33*(2), 176–195.
- Clay, S. (Ed.). (2005). *On our own, together: Peer programs for people with mental illness.* Nashville, Tenn.: Vanderbilt University Press.

- Daniels, A.; Grant, E.; Filson, B.; Powell, I.; Fricks, L.; & Goodale, L. (Eds.). (2010). *Pillars of peer support: Transforming mental health systems of care through peer support services*. Retrieved January 2010 from <http://www.pillarsofpeersupport.org/>.
- Davidson, L.; Chinman, M.; Sells, D.; & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, *32*, 443–450.
- Davidson, L.; Weingarten, R.; Steiner, J.; Stayner, D.; & Hoge, M. (1997). Integrating prosumers into clinical settings. In C.T. Mowbray, D.P. Moxley, C.A. Jasper, & L.L. Howell, (Eds.), *Consumers as providers in psychiatric rehabilitation*. Columbia, Md.: International Association for Psychosocial Rehabilitation Services, 437–55.
- Fricks, L. (2005). *Building a foundation for recovery: A community education guide on establishing medicaid-funded peer support services and a trained peer work force*. DHHS Pub. No. 05–8089. Rockville, Md.: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
- Mowbray, C.T., & Moxley, D.P. (1997). Consumers as providers: Themes and success factors. In C.T. Mowbray, D.P. Moxley, C.A. Jasper, & L.L. Howell. (Eds.), *Consumers as Providers in Psychiatric Rehabilitation*. Columbia, Md.: International Association for Psychosocial Rehabilitation Services, 504–17.
- Peebles, S.A.; Mabe, P.A.; Davidson, L.; Fricks, L.; Buckley, P.F.; & Fenley, G. (2007). Recovery and systems transformation for schizophrenia. *Psychiatric Clinics of North America*, *30*, 567–83.
- Salzer, M.S., & Mental Health Association of Southeastern Pennsylvania Best Practices Team. (2002). Consumer-delivered services as a best practice in mental health care delivery and the development of practice guidelines. *Psychiatric Rehabilitation Skills*, *6*, 355–82.
- Shepard, L. (1992). *So you want to hire a consumer? Employing people with psychiatric disabilities as staff members in mental health agencies*. Burlington, Vt.: Center for Community Change through Housing and Support.
- Simpson, E.L., & House, A.O. (2002). Involving users in the delivery and evaluation of mental health services: systematic review. *British Medical Journal*, *325*, 1–5.
- Solomon, M.; Jonikas, J.; & Cook, J. (1992). *Positive partnerships: How consumers and non-consumers can work together as service providers, 2nd edition*. Chicago, Ill.: University of Illinois at Chicago Center on Mental Health Services Research and Policy.
- Townsend, W., & Griffin, G. (2006). *Consumers in the mental health workforce: A handbook for practitioners*. Rockville, Md.: National Council for Community Behavioral Health Care.

23. How/where can you find funding for peer support services?

Many States currently provide reimbursement for peer support services through Medicaid and/or through managed-care companies. In other States, peer services

are primarily funded through Federal block grants and/or State dollars. Like other services, peer support services are and can be resourced through nonprofit enterprises, foundations, and local grant-making organizations, as well as through partnerships with research and community-based providers.

24. What are the various roles that people in recovery can play as service providers?

People in recovery can and do play various roles as service providers, depending on their life experience, educational attainment, and interest. There are, for example, psychiatrists, psychologists, nurses, social workers, and rehabilitative staff who are themselves in recovery. Some of these people identify themselves openly as being in recovery, while others do not. In this case, their professional training and experience is augmented by their firsthand experiences of illness, service use, and recovery.

For people in recovery who have not acquired such credentials or have no interest in doing so, there remains a range of services they can provide, in a range of settings. Peers can staff psychiatric rehabilitation programs as job coaches or developers, supported housing staff, or staff in psychosocial clubhouses; work on outreach and assertive community treatment teams as case managers or recovery specialists; and staff their own programs or work in collaboration with existing providers to offer respite care, recovery coaching, or recovery mentoring, acting as recovery support specialists or personal care attendants. Peer staff can also function as community connectors, linking people to arts or faith communities or to local organizations and activities, and as advocates, connecting people to legal representatives and rights groups.

There are no service roles for which peers should be considered ineligible or inappropriate, since such exclusion constitutes discrimination.

There are no service roles within the mental health field for which peers should be considered ineligible or inappropriate as a group, since such an exclusion based on a person's psychiatric history

constitutes discrimination under the 1990 Americans with Disabilities Act (Public Law 101-336 [42 U.S.C. Sec. 12101 et seq], 1990). Just as in the employment of anyone who does not have a history of mental illness, it is a matter of matching individual interests, aspirations, skills, and experience with appropriate employment opportunities.

25. Should peers work as peer specialists in the same clinic/program where they receive their own mental health care?

This is a matter of some debate within the field. Some agencies, especially those that are new to hiring self-identified peer staff, have established policies that such dual roles are not allowed. In that case, people in recovery who take on jobs as peer staff in agencies where they are receiving services are asked to terminate those services and seek their own care elsewhere. This is not always possible, as in rural settings, where that agency may be the only care provider agency, or for people requiring specialized care that may only be offered by the agency where they work.

In addition, arguments can be made that employment in mental health settings should require no additional regulations or prohibitions than employment in other healthcare settings. In this case, it would be a matter of personal choice on the part of the person as to where he or she wishes to receive care, much as it would for a nurse or doctor who works in a primary care practice. Challenges—based on concerns about confidentiality and the Health Insurance Portability and Accountability Act (HIPAA)—raised about this issue assume that these concerns are somehow different for peer staff than they are for any staff, which is not the case. All mental health staff are bound by confidentiality and HIPAA provisions and are only to access and share personal health information when required by the nature of the person’s role or with the patient’s permission. These provisions apply to all staff, including, but not especially, peer staff. Denying peer staff access to medical records that would otherwise be accessed for the purposes of treatment and care simply because the person has a history of mental illness is discriminatory, as is having separate lunch rooms for peer and nonpeer staff, or other markers of differentiation, such as access to keys, agency vehicles, restrooms, and more.

This is not to say that people who are openly in recovery don’t face particular challenges, as they overcome stigma within mental health systems that have not yet recognized the important skills and experience they bring to their work. More subtle forms of discrimination for peer workers within mental health settings continue to be of concern and require additional research and work to fully understand and to ameliorate. An important beginning step to ensure that peer workers are respected and valued is to ensure that the leadership within an organization understand, encourage, and publicly champion the contributions of peer workers.

26. How can program directors take a leadership role in motivating their staff to become recovery-oriented and develop true partnerships with clients?

Perhaps the most important thing program directors can do in taking a leadership role is to model the values and principles of a recovery orientation. This includes treating clients, but also staff, with dignity and respect; embodying a hopeful stance in believing that

The most important thing program directors can do is to model the values and principles of a recovery orientation.

improvements and recovery are possible (again, for both clients and staff); involving clients in all aspects of program design, operation, policy and procedure development, training, and monitoring (e.g., quality improvement and other workgroups or committees); and focusing primarily on the identification and promotion of strengths, rather than on deficits and problem-solving. Recovery-oriented practice seems easier to implement through the provision of incentives than through punitive means, and “pockets” of quality (either individual staff or specific programs that exemplify recovery-oriented practice) can be given visibility and praise. In New Zealand, for example, the Mental Health Commission published a book highlighting a number of exemplary recovery-oriented practitioners that was very well-received (Mental Health Commission of New Zealand, 2001).

In terms of partnerships, practitioners may need to be assured that they will not be blamed or held accountable for the “mistakes” their clients might make, should a practitioner choose to begin encouraging responsible risk-taking on the part of their clients. (While practitioners have never actually been able to control their clients’ behaviors outside of hospital settings, they have occasionally been led to believe that they are nevertheless responsible for that behavior.) Recovery-oriented leaders can motivate staff to adopt collaborative relationships with clients by acknowledging that people’s actions can’t really be controlled anyway and by helping staff to learn and practice motivational enhancement and de-escalation techniques as more effective alternatives to coercion and control.

27. How does the relationship between the practitioner and the service user change in recovery-oriented practice?

Within the context of recovery-oriented practice, the relationship between a practitioner and service user is collaborative in nature, with both parties entering into a partnership with the common aim of promoting the person’s recovery. For practitioners who believe they are already working with their clients in a collaborative fashion, going over some of the more specific features of person-centered care might help them to embody this attitude more concretely in their work. As the devil can be in the details, tools—such as the Recovery Self-Assessment (O’Connell et al., 2005) and the Person-Centered Care Questionnaire (Tondora & Miller, 2009)—can be helpful in focusing practitioners on ways of making their relationships more collaborative.

These tools include such guiding statements as:

- “Each person has the chance to review and make changes to his or her plan.”
- “I offer each person a copy of his or her plan to keep.”
- “I try hard to understand how each person accounts for what has happened to them and how they see their experiences based on their cultural background.”
- “Each person is involved in the treatment-planning process as much as he or she wants to be.”

- “I remind each person that she or he can bring family members, friends, or an advocate to recovery-planning meetings.”
- “Staff listen to, and respect, the decisions that program participants make about their treatment and care.”
- “Program participants can easily access their treatment records if they wish.”
- “Program participants can change their clinician or case manager if they wish.”
- “Staff believe that program participants can make their own life choices regarding such things as where to live, when to work, whom to be friends with, etc.”

28. How can a practitioner adopt recovery-oriented practices within the context of a traditional or conventional mental health program or setting?

Some changes can be made within conventional settings, such as identifying and focusing on a person’s strengths, changing the way people are described according to non-stigmatizing and recovery-oriented descriptors, helping people see beyond symptom reduction and “maintenance” to rebuilding a life in the community, and educating people about self-help tools such as the Wellness Recovery Action Plan (known as WRAP) (Copeland, 1997) or *Pathways to Recovery* (Ridgway et al., 2002). The introduction of such changes will generate the added benefit of helping a conventional program to become more recovery-oriented, culturally responsive, and hopeful over time.

There are certain aspects of conventional care, however, that are challenged by, and inconsistent with, recovery-oriented practice, and these aspects will limit the extent to which individual practitioners can transform their own practice. Such aspects include:

- Rigid rules and schedules that do not allow for tailoring care to each individual’s needs and preferences (e.g., everyone must awaken at 7:00 a.m. and shower by 7:30 a.m.; appointments for mental health care can only be made for between 9:00 a.m. – 4:00 p.m., meaning that a person who works or attends school will have to miss school or work to meet with a practitioner; a person must attend X number of groups or X days per week to stay in this program)
- A lack of sufficient time to spend with people to get to know them as individuals (e.g., unreasonable caseload sizes, “med check” appointments every 10 minutes, etc.)
- A prohibition on taking one’s practice out into the community settings where people live, work, and play (e.g., to be billable, services have to be provided within the clinic)

- Arbitrary restrictions placed on people’s freedom to make their own choices (e.g., imposition of a mandatory work-ordered day, limitations on visitation by loved ones, refusal to allow clients access to their own medical records, etc.)
- Continuing to focus clinical rounds around “problem patients” or areas of deficit, to use stigmatizing and pejorative language, to offer problem-focused examples, to focus on “compliance” and “risk-management,” and to have a lack of support for staff using creative and recovery-oriented strategies to engage clients (e.g., taking a walk with a client during a clinical session because he feels claustrophobic and anxious in the clinician’s office).

29. What kind of culture change is required to support recovery-oriented practices?

What this change will look like and how it will be achieved depends on many more factors than can be discussed here. At its heart, the change required to support recovery-oriented practices is from a practitioner and program-driven

The change required is from a practitioner- and program-driven culture to a person- and client-driven culture.

culture, in which patients or clients were expected to fit into or take up “beds” or “slots,” and to benefit from whatever was offered in a one-size-fits-all fashion, to a person- and client-driven culture in which people and their loved ones can choose, from an array of meaningful options, those services and supports that are most likely to assist and support them in leading the kind of life they wish to lead. Also important is a change from a risk-averse culture focused on diagnoses, deficits, dysfunction, and disability to a culture that celebrates people’s strengths, contributions, and cultural diversity, and that encourages responsible risk-taking.

Finally, changing language is an important means of supporting and sustaining culture change. Examples include using person-first language rather than describing people based on their diagnoses and viewing problems and difficulties as challenges people are facing in their lives rather than reinforcing them as permanent barriers to progress or well-being. As the sociologist and social advocate John McKnight has said, “Revolutions begin when people who are defined as problems achieve the power to redefine the problem” (McKnight, 1992). It is essential to recovery-oriented system change that people with serious mental illnesses are no longer viewed as “the problem,” but instead are seen and treated as people who are doing their best to deal with, and overcome, difficulties that have happened to them. Far from being “the problem,” the recovery community is a primary source of the solution.

30. How are recovery-oriented services funded? Are they supported by Medicaid and/or Medicare?

First, we should note that many recovery-oriented practices and services, as we've discussed above, don't require additional funding. For those that do, there are more and more opportunities for funding from traditional sources (e.g., State and local governments, private foundations, National Institutes of Health or SAMHSA grant funding) as people recognize not only the value of recovery-oriented services, but their effectiveness in real-world settings. Currently, many recovery-oriented services are funded by Medicare and Medicaid, depending on each State's Medicaid plan. The focus of recovery-oriented practice on person-centered and goal-directed care is highly consistent with Medicare and Medicaid regulations and provisions, as well as with Joint Commission and CARF (originally the Commission on Accreditation of Rehabilitation Facilities) standards. Where difficulties often enter into the picture is when Medicaid explicitly excludes certain recovery-oriented practices, such as supported employment or transportation, assuming perhaps that these services will be reimbursed or funded by other agencies. In addition, the traditional focus of Medicaid on medical-necessity criteria for billing purposes poses a challenge to the strength-based focus of recovery-oriented care and its orientation to a quality life in the community. The hope is that as these agencies also are transformed over time through healthcare reform, the funding support for recovery-oriented care will not be quite as much of a patchwork quilt as it currently is.

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