The Council on Quality and Leadership

What is Recovery?

Cherene Allen-Caraco

CQL "Brown Bag Lunch and Learn" Series
May 5, 2015

A little context…

CQL Recovery Consultant for 4 years

Person in recovery for 27 years

Chief Executive Office, Promise Resource Network
www.promiseresourcenetwork.org
Recovery Hub, Recovery University, Work4Recovery, Peer Academy

There is a great deal of national, international and local interest regarding the concept of Recovery.

It is the subject of research, articles, books, system reform, measurement tools, training, advocacy efforts and program development.

Department of Justice

A Statewide focus on Olmstead and ADA
-New Jersey
-Delaware
-Georgia
-North Carolina

Olmstead - 1999

Community Integration for All

Adult Mental Health Recovery-Oriented System of Care

Services and supports shall be:

- evidence-based
- community-based;
- recovery-oriented;
- flexible and individualized;
- focused on helping individuals increase their ability to recognize and deal with situations that may otherwise result in crises; and
- focused on increasing and strengthening individuals' networks of community and natural supports, as well as their use of these supports for crisis prevention and intervention.

Recovery and National Reform

With the success generated from other states, the recovery model has become a tool for guiding system reform at the state level in both policy and practice throughout the United States.

Some states have taken it upon themselves, others have been influenced by President Bush's New Freedom Commission Report, a process that began in **2001** to promote increased access to educational and employment opportunities for people with disabilities, to maximize the use and effectiveness of existing resources, to improve coordination of treatments and services and to promote community integration.

To make comprehensive recommendations, the New Freedom Commission analyzed public along with private mental health systems, visited innovative programs, and met with consumers, families, advocates, providers, researchers and administrators. Feedback was provided from **2,500** people from all 50 states.

Their final report, **"Achieving the Promise: Transforming Mental Health Care in America"** concluded that recovery from mental illness is real; however, due to a fragmented system and inadequate resources, efforts toward recovery are thwarted.

Why Recovery?
The Emergence of the Recovery Model
Mental Health Transformation and Recovery

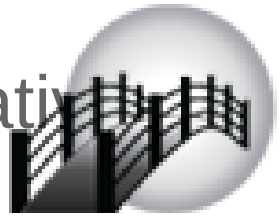
The Commission stated, "treatments and services that are based on rigorous clinical research languish for years rather than being used effectively at the earliest opportunity… the lag between discovering effective forms of treatment and incorporating them into routine patient care is unnecessarily long, lasting about **15 to 20 years."**

"The report concluded that the system is not oriented to the single most important goal of the people it serves - the hope of recovery. State-of-the-art treatments, based on decades of research, are not being transferred from research to community settings. In many communities, access to quality care is poor, resulting in wasted resources and lost opportunities for recovery. More individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs."

One of the recommendations detailed is that institutional care must be replaced with efficient, effective community services that focus on Recovery. The clear recommendation is a fundamental transformation of how mental health care is delivered in America.

When combined, consumers' voice, research, funding cuts and managed care, as well as the President's New Freedom Initiative, all resulted in the model of recovery serving as the template in which to reform the system of mental health.

SAMHSA Recovery To Practice Initiative



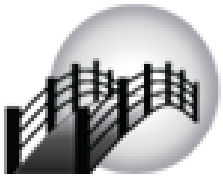
RECOVERY TO PRACTICE
Resources for Behavioral Health Professionals

Focus Areas:

- American Psychiatric Association
- American Psychological Association
- American Psychiatric Nurses Association
- Council on Social Work Education
- National Association of Peer Specialists

Goals:

- hasten awareness, acceptance, and adoption of recovery-based practices, approaches and model in the delivery of mental health services
- Further transform our mental health system to advance personal recovery
- Increase collaboration across disciplines
- Disseminate up to date research on evidence, evidence based and promising practice



RECOVERY TO PRACTICE

Resources for Behavioral Health Professionals

The *Recovery to Practice* initiative includes two complementary components:

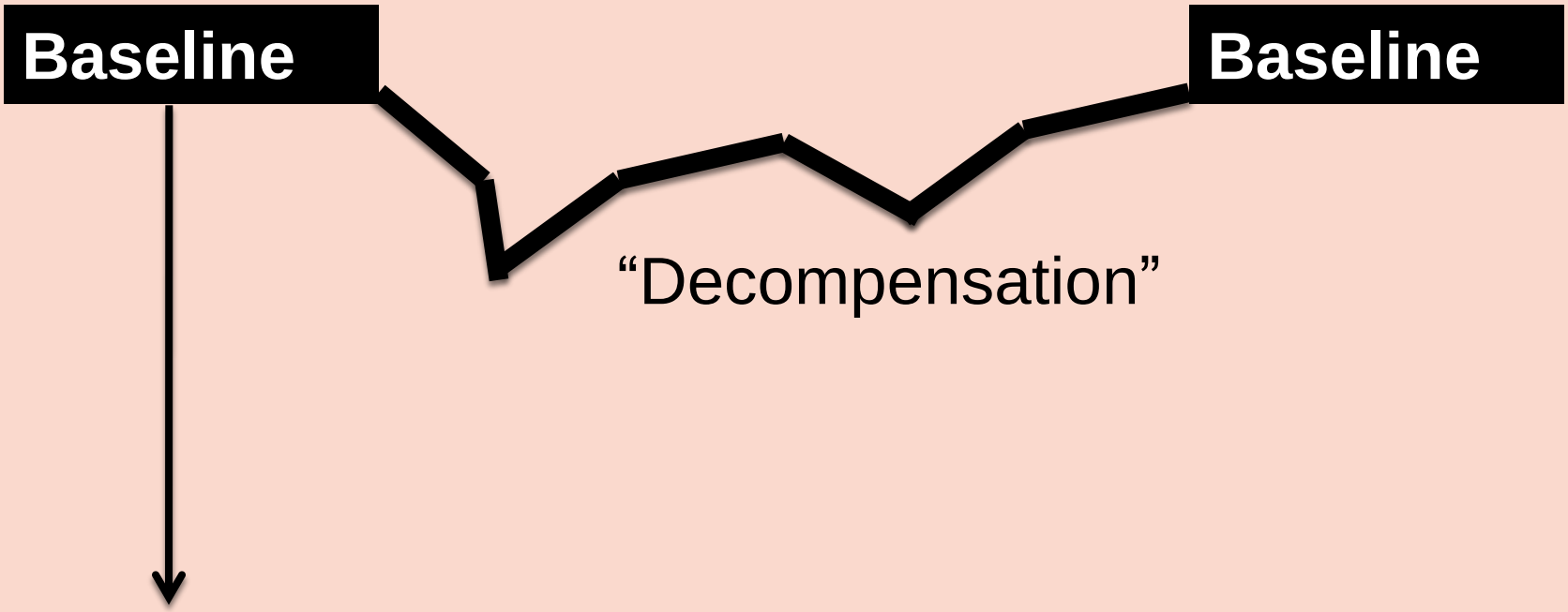
- 1) Creating a Recovery Resource Center for mental health professionals complete with Web-based and print materials, training, and technical assistance for professionals engaged in the transformation process; and

- 2) creating and disseminating recovery-oriented training materials for each of the major mental health professions. Through these two major components, the RTP initiative aims to foster a better understanding of recovery, recovery-oriented practices, and the roles of the various professions in promoting recovery.

Components of the "Medical Model"

- Monitoring Mental Illness
- Low Expectations
- Problem Focused
- Team/MD in control
- Social Isolation
- Lack of User Involvement
- Focus on Medication
- Lack of Privacy
- Dependence
- Safety and Security
- Service for Life
- Hospital Based
- Providers have power
- Low risk tolerance
- Teaches Helplessness
- Call 911 when in Crisis
- Expensive!

“Medical” or “Maintenance” Model

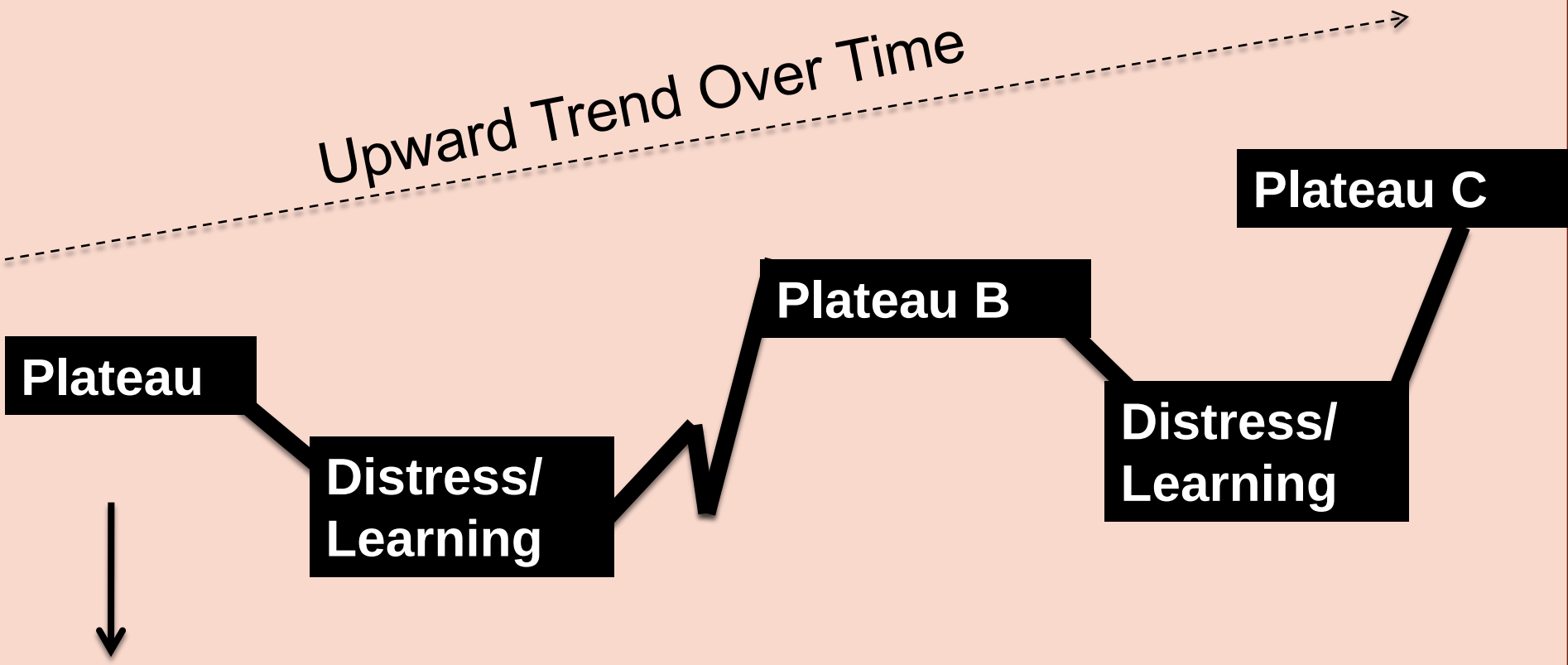


Primary Concern: Symptom reduction, reliance on medication, low-stress to stay stable, no risk.

Recovery Model

- Broadening Mental Health
- High Expectations
- Solution Focused
- Self-Management
- Social Inclusion
- User Partnerships/Alliances
- Focus on Growth
- Sense of Privacy
- Interdependence
- Focus on coping skills
- Risk vs Benefit weighed by person
- Learning self-reliance
- Community Inclusion
- Person is empowered
- Resources in a crisis
- Progressively less costly!

"Recovery" Model



Primary Concern: Whole person, …..

What is it like to live with the impact of emotional distress and psychiatric labels?

The Patient Identity:

The Culture of “Patienthood”

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WHO AM I?

- Am I Bi-Polar?
- A schizophrenic?
- A patient, consumer and client?
- A mother/father
- A son/daughter
- A student

- A……. **PERSON**!?!

How Are People With Mental Illness Perceived By:

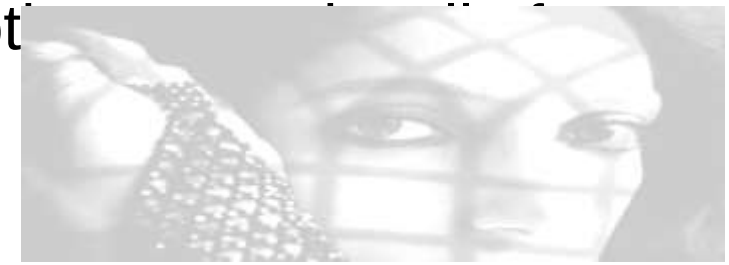
SELF-STIGMA

Stigma:

something judged by others as a mark of disgrace or shame and which can set one apart from everybody else.

Self-Stigma:

when a person begins to define or see themselves in a stigmatizing way. For example, when you are treated as incapable due to a mental health challenge, you may start to see yourself as incapable and begin to behave as though you are, relying on ot
decisions for you.



"PATIENTHOOD"

An example of a Self-Stigmatizing identity is that of a patient. What does it mean to be a patient? How do you spend your time? Who is in control of your life? How does this impact what you think about yourself?

Who Am I?

"Patienthood":

Negative Sense of Self:

Shame, feeling unworthy, self loathing, fear, distrust of self,

identity based on label/ diagnosis/symptoms, pessimism, invalidation, criticism, unwilling to take risks, lack of knowledge, information withheld

Lack of Meaning and Purpose:

Being and accepting stagnancy

Self absorption, helpless, hopeless

Who Am I?

Have you ever wondered who you are? As a person, your beliefs, wants, likes, values? Trying to figure out who we are is common for all people.

When you have a mental health and/or addiction challenge, it could be even more important to discover your identity.

Do you think that sometimes you fall into the trap of seeing people you serve as or sick, broken or ill?

How can we, providers, recognize if someone else is seeing themselves through the lens of their diagnosis?

What could be the outward signs?
What can be their behavior, demeanor, things they say,
How do they present themselves, how do they spend their time, etc.

The Culture of “Patienthood”

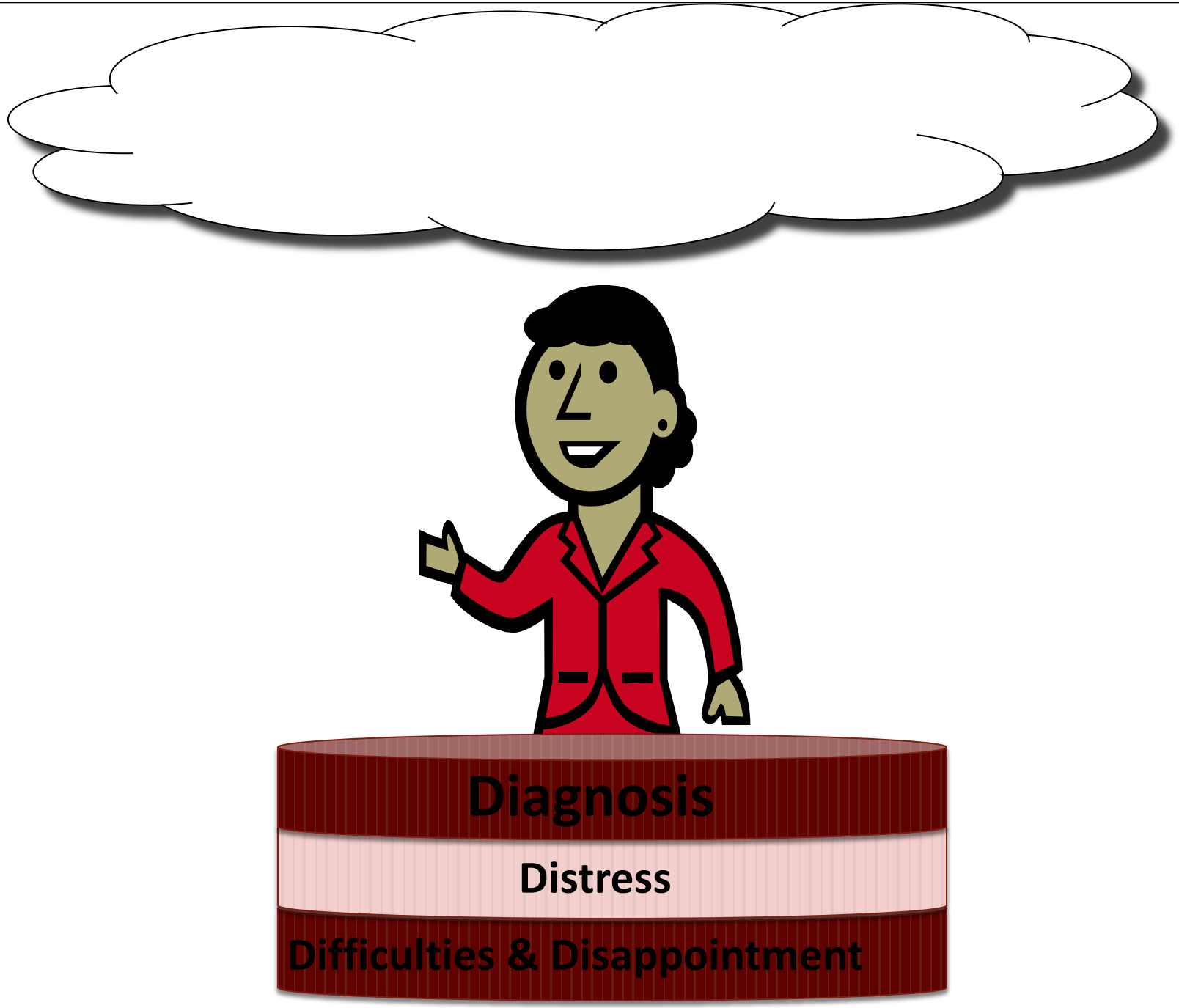
- Overuse of medications
- Deficits based
- Lack of voice, choice and ownership
- Viewed as incapable
- Alienation
- Forced treatment

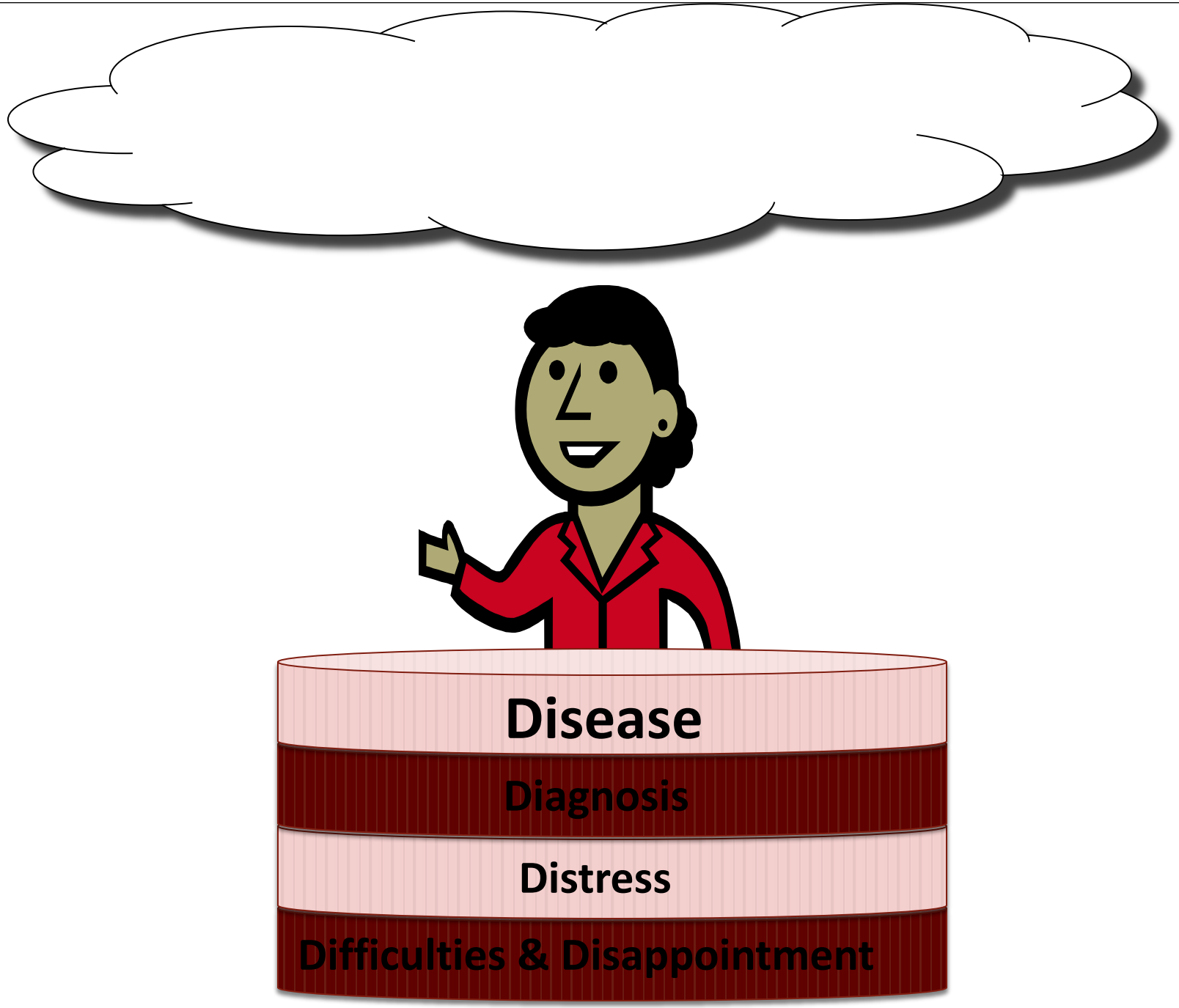
“To Be A Mental Patient”

- To be a mental patient is to be stigmatized, ostracized, socialized, patronized, psychiatrized.
- To be a mental patient is not to matter.
- To be a mental patient is to wear a label, a label that never goes away, a label that says little about what you are and even less about who you are.
- To be a mental patient is to act glad when you're sad and calm when you're mad.
- To be a mental patient is to participate in stupid groups that call themselves therapy -- music isn't music, it's therapy; volleyball isn't a sport, it's therapy; sewing is therapy; washing dishes is therapy.

Rae Unzicker 6/84

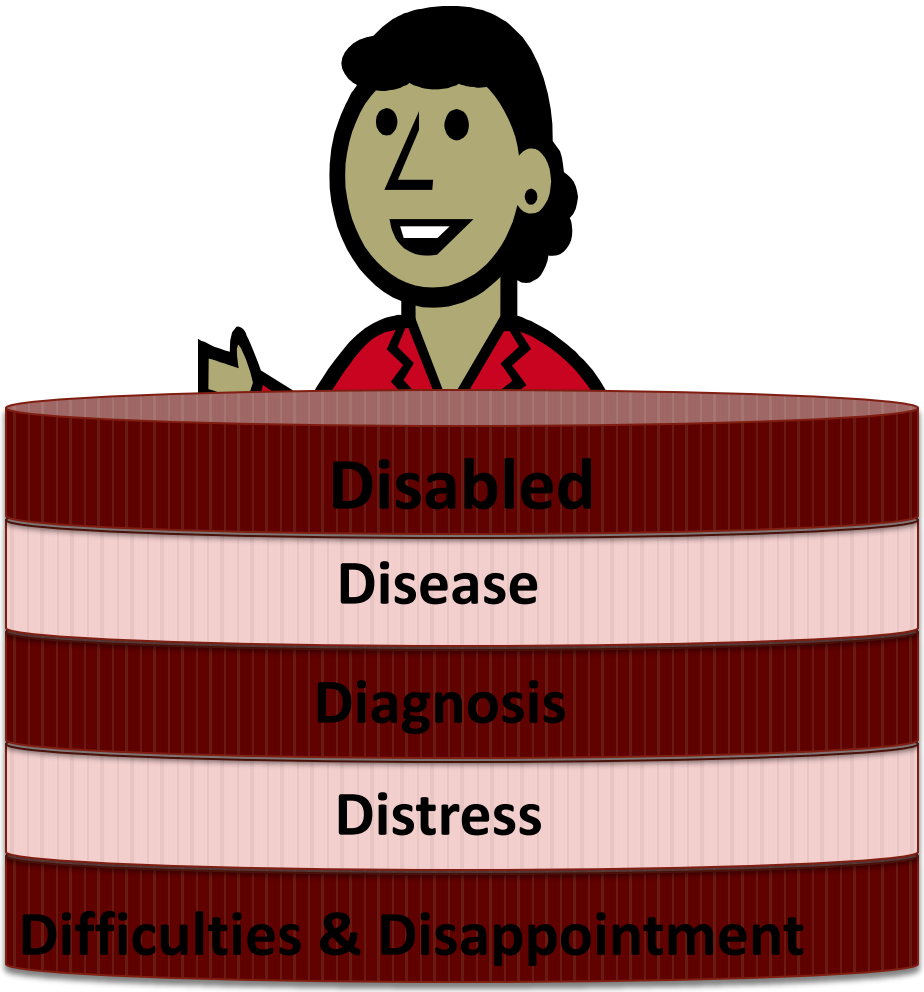
The ‘D’ List





D List

Deficit Based



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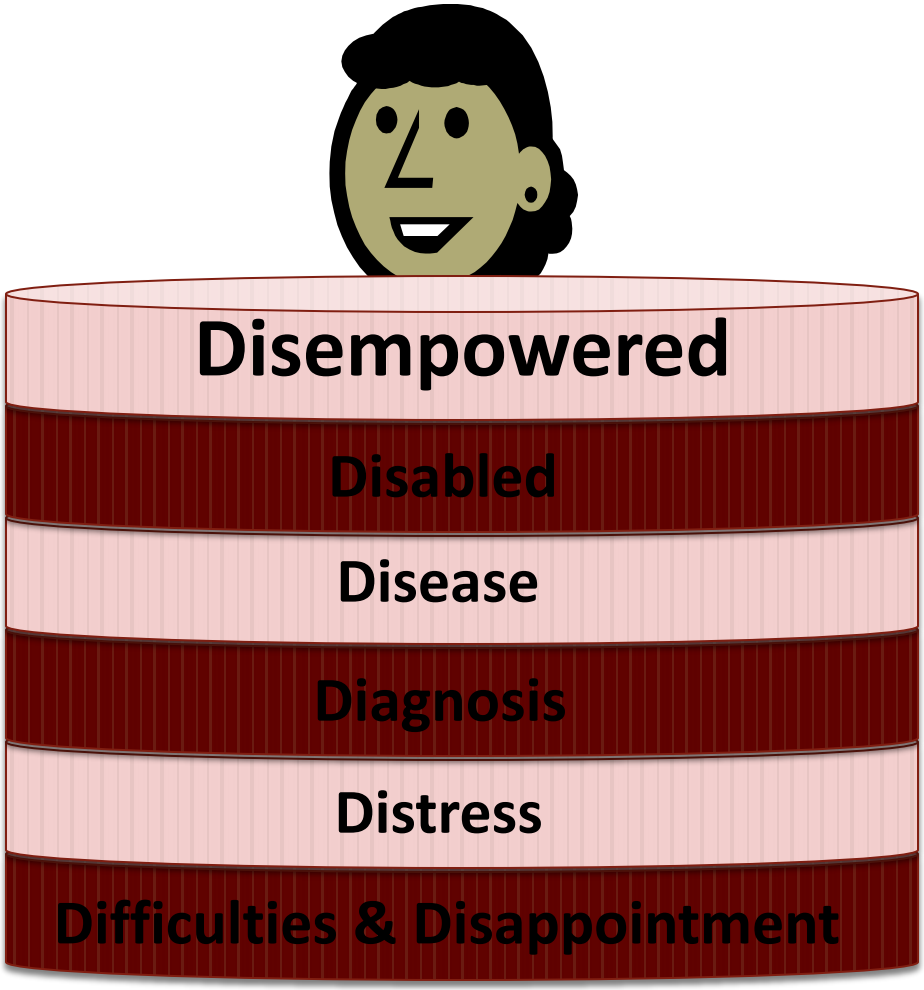

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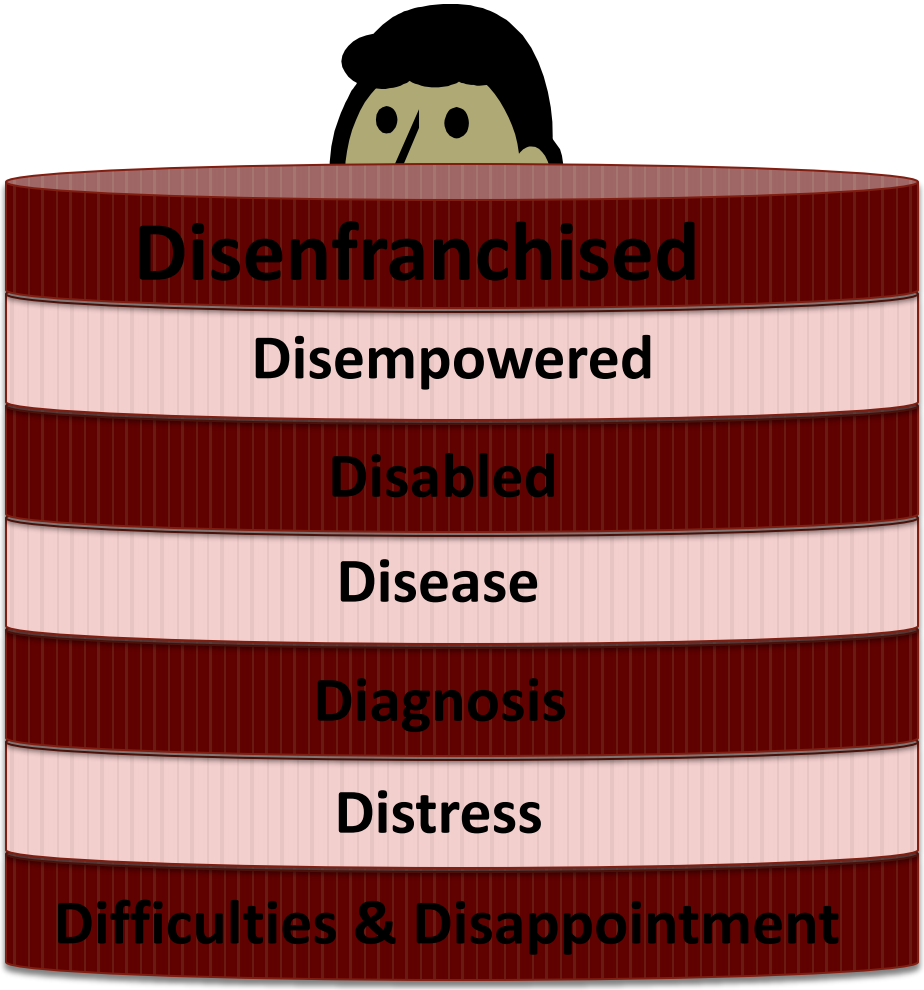

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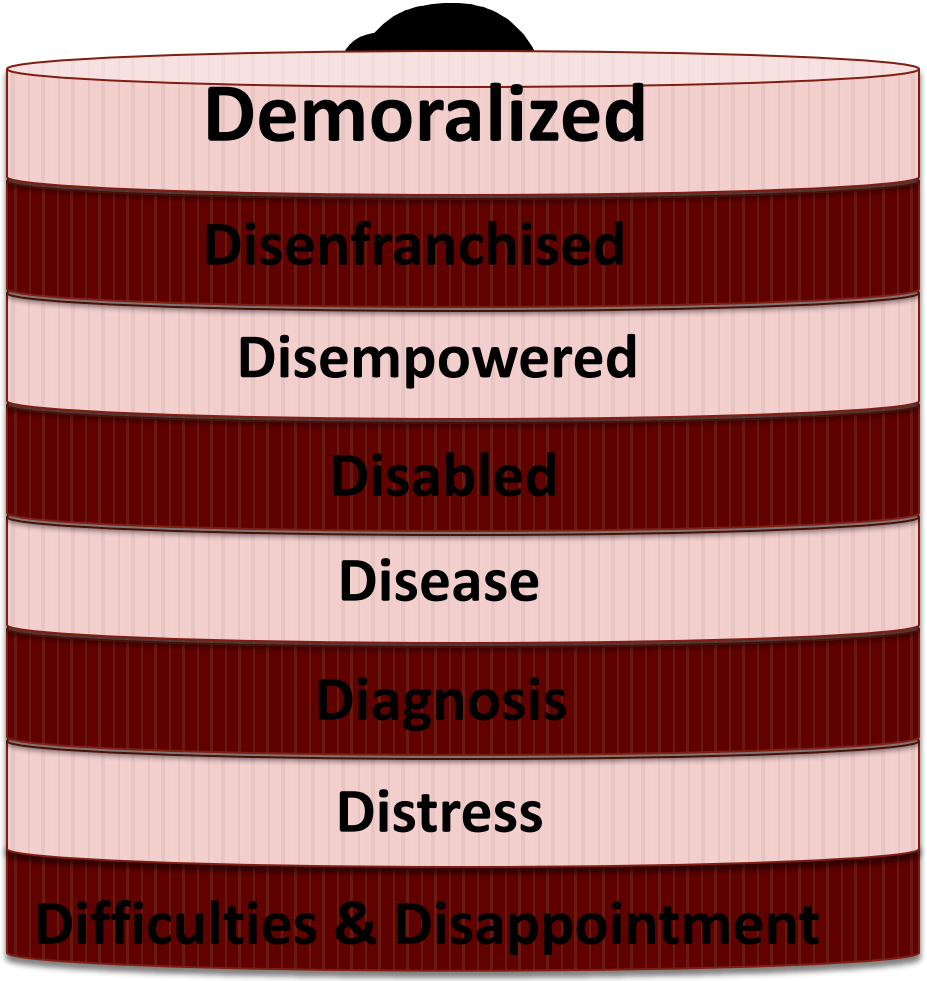


D List

Deficit Based

And the person disappeared

These messages are:

Life Altering

Spirit Breaking

Identity Shattering

Hope

Diminishing

Soul Crushing

Impact of “Patienthood”

Seeing yourself as a patient can mean seeing yourself as:

Helpless
In need of others to care for you
Dependent
Unable to make decisions
Broken
Incapable of working
Sick

And what does that do to your self-esteem? How does that affect your confidence, behaviors, thoughts, beliefs?

…and perception becomes REALITY

Where does this come from?

But You're *NOT* Like MY Consumers!!!

"The Clinician's Illusion"

What's Contributing to this….

Outdated attitudes, lack of knowledge about recovery research and outcomes.

Lack of innovation, progress and real solutions . We continue to look for solutions in what we have available instead of creating solutions that actually work.

Lack of opportunity for wellness due to paternalism and low expectations… "you can't work!" Also, disincentives for employment keeps people sick!

A system designed around Stabilization and Maintenance that focuses on quantity, not necessarily quality

Business as usual: Archaic treatments and approaches that keep people ill and stuck in patienthood. We are not investing in community resources, only community services

Our focus is on adding MORE services, rather than enhancing recovery through improving the services we have. Pay for best practices, recovery and psychiatric rehabilitation not treatment and care taking

Not valuing the lived experience- no partnerships, no hiring people in recovery or utilizing them in valued roles, no asking people who live it everyday for solutions

What is Recovery?


Recovery
in
Mental
Health

What Is Recovery?

Webster's Definition:

"To Get Back: Regain" or
"To Restore to A Normal State"

(Webster's II New Riverside University Dictionary, 1984).

WHAT IS RECOVERY?

What Is Recovery?

Personal Definitions…

Individual Recovery is….

"… letting go of old ideas and embracing new ones. Rather than a "should have,"" could have" fear based mentality, I accept me in all my glorious strengths. I was created exactly the way I was meant to be! Kiss my A_ _, you demons from the past!!!"

"…understanding who I am, where I have been, how I got there, and how to forget and forgive to move forward. I will survive no matter what anyone says about me or tries to do to me to pull me down."

Recovery IS…..

- Defined by the person
- Often referred to as a process or journey
- Involves self awareness, identity and esteem
- Hard work! No magic pills or treatments
- Having or getting a life. The one you want, not the one others want for you
- May include recovering what you have lost… rights, dignity, responsibilities, purpose
- Rekindling hope and being able to dream
- Overcoming, healing, transforming
- Possible and probable!

Recovery Is….

"No longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self"

(Review of Recovery Literature: A Synthesis Sample of Recovery Literature 2000)

What Is Recovery?
National Consensus Statement on Mental Health Recovery

December, 2004

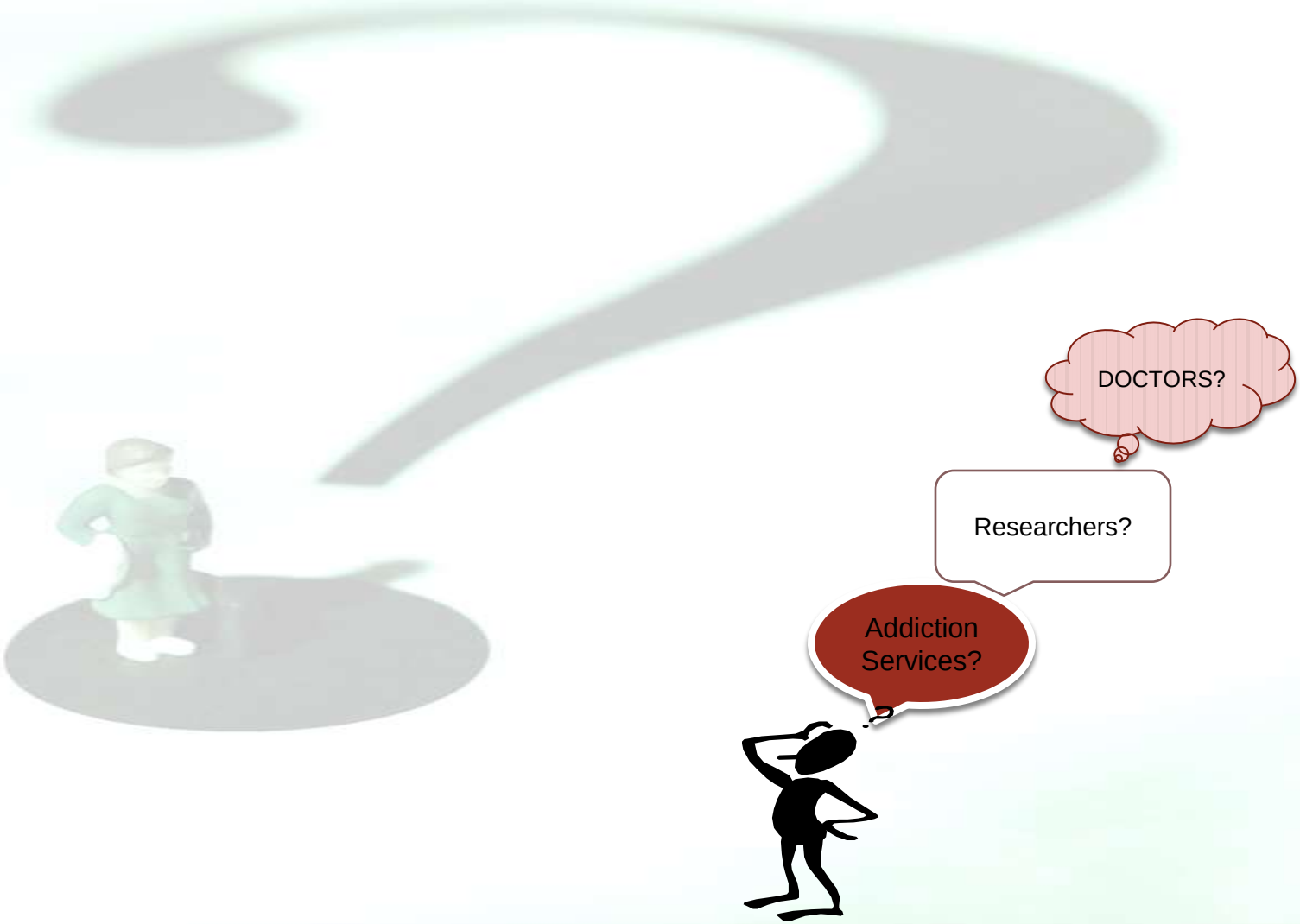
United States DHHS—SAMHSA division convened 110 expert panelists who studied research, technical papers, reports, and their own experiences. The panel included consumers, families, providers, advocates, officials and representatives from seven Federal agencies:

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

Individual Recovery is *not*…

- Stabilization, functioning or maintenance
- An exception
- Compliance
- Formulaic
- Something someone else can do for you
- Simply being nice to people we serve
- A cure or removal of symptoms (although, people do experience this)

Where Did The Notion of Recovery come From?



Personal Accounts of Recovery

There exists thousands of written, published, and unpublished accounts of people with serious mental illness or severe and persistent mental illness recovering.

These personal stories of Recovery have yielded much information on what Recovery is, how people Recover and ways to support and enhance Recovery.

Why Recovery?
The Emergence of the Recovery Model

The *concept* of Recovery emerged from consumers reaction to the treatment they received:

overuse of medications

lack of choice

use of force

focus on deficits and diagnoses

Beginning in the early 1980's, personal accounts of mental wellness began to emerge. Initial "stories" of consumers' journeys to wellness did not use the word "recovery," rather, they opted for words such as well-being and mental wellness.

The word "Recovery," as it related to mental illness, was first used in the late 1980's in a consumer writing by Pat Deegan with *"Recovery: The Lived Experience of Rehabilitation"* and again in the early **1990's** in a non- consumer commentary, *"Recovery from Mental Illness: the Guiding Vision of the Mental Health System in the 1990's."*

The Emergence of the Recovery Model
"Consumers Speak"

As consumers talked….
professionals listened!

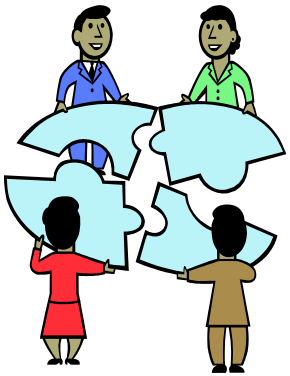
Consumers employed by systems management and involved in planning, policy making, program evaluations and service provision at the Offices of Consumer Affairs.

Consumers emerged as the experts, and were saying Recovery IS Possible!

Consumer-oriented research began and focused on Recovery

To give a more credentialed voice to Recovery, consumers began obtaining their PhD's, becoming therapists and psychiatrists

Do People Recover From Mental Illness?



"Recovery research tells us that, given the right combination of attitudes and supports, people can fully recover from mental illness."

-Dan Fisher, MD, Ph.D.
Consumer, Psychiatrist and Advocate

Do People Recover From Mental Illness?

- *Truth*

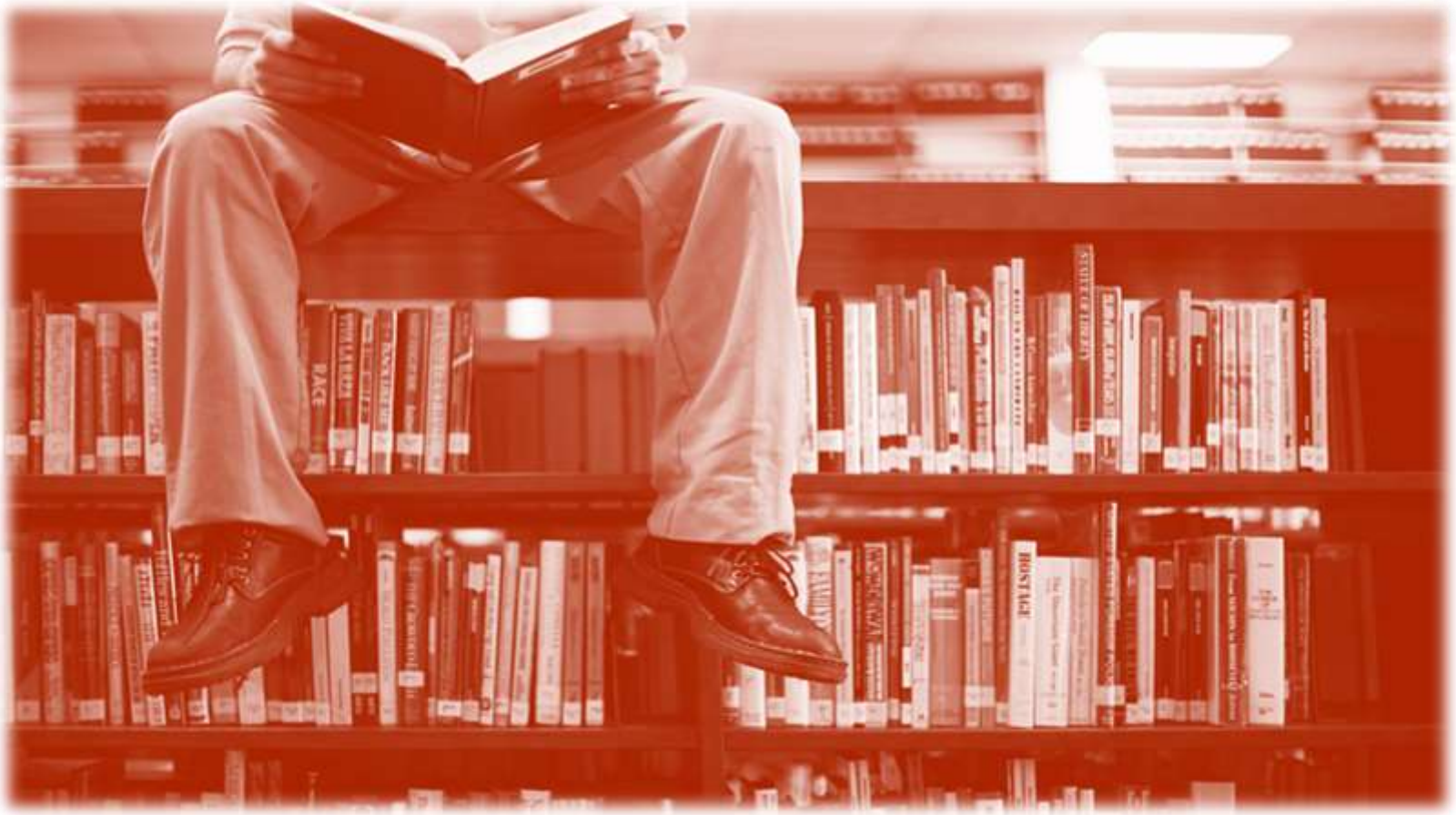
Research supports

that Recovery from mental illness is not a unique phenomena. When a recovery-orientation is utilized to support people, Recovery is enhanced.

- *Myth*

Recovery is possible for only a few select People with mental Illness. People who have had lifelong symptoms and hospitalizations, can only expect stabilization.

Research on Recovery began 30-40 years ago.



Harding, et al.

The Vermont Study

- 32 year longitudinal study
- Most severely disabled - bottom 19% in their state hospital
- Most had been at the hospital for over 10 years
- Study participants in planned deinstitutional rehabilitation plan
- Status at 32 years recorded

62-68% **fully recovered or significantly improved**

Is Recovery Possible?
The Vermont Study

Recovery was based on the following criteria:

- Having a social life indistinguishable from your neighbor (being integrated into the community)
- Holding a job for pay or volunteering
- Being symptom free (no current signs and symptoms of mental illness)
- Being off medication

Study	Average Length in Years	Sample Size	Subjects Recovered and/or Improved Significantly
M. Bleuler (1972 a & b) Burgholzli, Zurich	23	208	68%
Huber et al. (1975) Germany	22	502	57%
Ciompi & Muller (1976) Lausanne Investigations	37	289	53%
Tsung et al. (1979) Iowa	35	186	46%
Harding et al. (1987 a & b) Vermont	32	269	68%
Ogawa et al. (1987) Japan	22.5	140	57%
DeSisto et al. (1995 a & b) Maine	35	269	49%

(Center for the Study of Issues in Mental Health, 2003)

Research on Recovery dispels the notion of mental illness as a chronic, deteriorating condition and concludes that Recovery can be supported or deterred by a combination of environmental and psychosocial factors.

(Mental Health Recovery: What Helps and What Hinders, 2002)

The Good News

Organizations, services, systems and people can ***enhance*** recovery!!!

The Bad News

Organizations, services, systems and people can ***hinder*** recovery.

But what's around us can HELP or HINDER the recovery process

Recovery is Ours Alone

Recovery: Back to the Basics….

What do people with mental health challenges want? How does this compare to what YOU want?

1. Meaningful ways to contribute. People need meaning and purpose. If tomorrow looks like today, what's the point? Opportunities for meaningful employment- not the 4F's (food, flowers, filth and factory)

2. To Love and be loved. In everyway possible- friendships, companionship, intimacy

3. Value. To have an identity other than mental patient, consumer or client. To be a homeowner, tenant, sister, aunt, mother, brother, husband, student…

4. Safety, Respect, Rights, Personal Control. *Stop the forced treatment, coercion, and threats under the guise of treatment. It DOESN'T work!*

Recovery: Back to the Basics….

5. Choice, Options and Opportunities based on what they value. *"I don't want to go to bed at 6pm. I want to choose what to eat, I want to sleep in on weekends!"*

6. HOPE! Hope that I can have a life that I find worth living, that I can work, have a home, have a family.

7. A HOME

NOT a placement
NOT a slot
NOT housing

…. A home! This is typically NOT a congregate care setting, NOT a group home or transitional housing. People want a REAL home!

What have people told us about their recovery Experience? (i.e. what have we learned from the Experts?)

1. Having someone who truly believed in me and that I could recover made the difference

2. Having the opportunity to replace my role as patient, client and consumer with one that was employee, student, homeowner, tenant, colleague, that completely changed my identity, beliefs, confidence and view of my future.

SAMHSA's Definition of Recovery:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

4 Dimensions of Recovery

Health
Home
Purpose
Community

8 Dimensions of Wellness

Emotional
Environmental
Financial
Intellectual
Occupational
Physical
Social
Spiritual

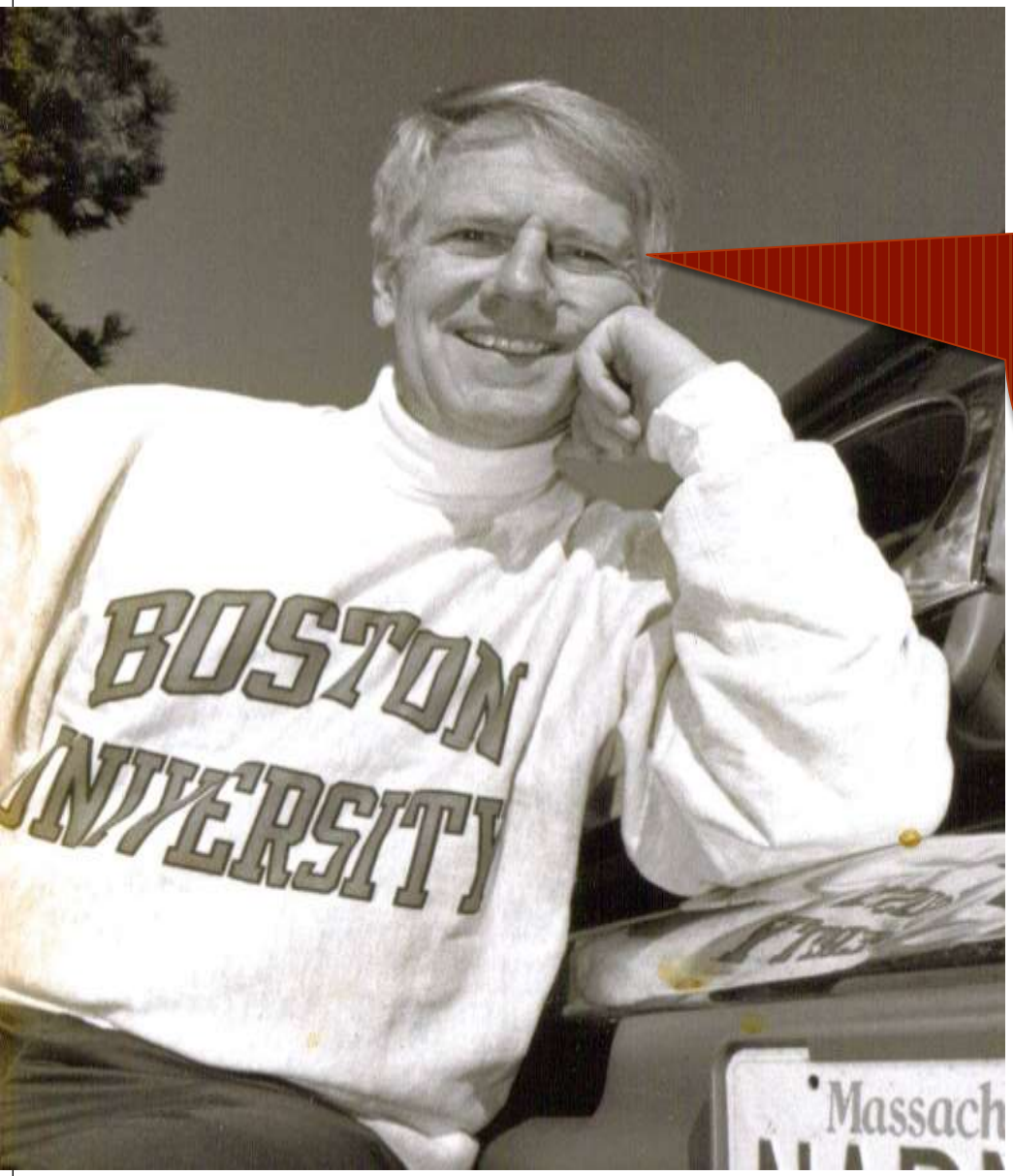
The Eight Dimensions of Wellness

PSYCHIATRIC REHABILITATIO N

SKILLS + SUPPORTS= Success & Satisfaction

- Psych Rehab reframes the discussion from illness-based deficits to learnable skills.
- Psych rehab focuses on skills and abilities, S+S=S&S
- Psych Rehab is a way to break big activities into smaller steps.

Emotional Distress



What If…?

What If….

What If….


Learn through Experience
Build Skills
Provide Opportunities
Acquire Supports
CAN
Unlearn Negative Messages
Dignity of Risk

Mission of Psych Rehab

Support the person to get the skills and supports needed to be successful and satisfied in his/her environment of choice

GOAL

S+S=S&S

Skills + Supports = Success & Satisfaction

Living up to the expectations of the environment, as defined by the environment

Living up to your own needs to be fulfilled & happy, as defined by the YOU

Psych Rehab Approach

Framework for IDDT, Supported Employment, Supported Education, Supported Housing (all EBPs), Person Centered Planning and contemporary approach to ACT

Values Based Approach

A value based approach means that the interventions are relevant to what the person wants and needs and its contribution to the outcome(s) desired by the person. Simply having a skill building activity is not in and of itself rehabilitative if it is not meaningful or valued by the individual (e.g. “anger management” vs. skills to tolerate feedback from my supervisor).

Making the Case for Work

What Is…

Vocational Recovery?

Paths to Vocational Recovery?

Employment Rates?

Vocational Recovery

Unemployment Rate…

about **85%**

Say that they **want** to work.

70%

Vocational Recovery means…

…recovering your meaning, purpose and identity!

Employment is a PATH to Recovery!

For most people who have experienced emotional distress, employment is part of their recovery.

Employment Works!
Research findings

- significant improvement in social skills after 17 weeks of job placement.
- significant symptom improvement and fewer hospitalizations.
- participants who were in employment after 18 months tended to have
  - lower symptoms (particularly thought disorder) and better self esteem
  - more satisfaction with their finances and vocational services than those who were unemployed.
- an increase in independence, an improved sense of self worth and an improved family atmosphere.

Employment Myths

… people with mental health and substance use challenges…

1. Do NOT want to work:

   unmotivated, working the system, non compliant

2. Are unable to work:

   incapable of holding down a job, not intelligent or skilled to have a "regular" job

3. Should not work:

   "it's too stressful!"

Employment Truths

… people with mental health and substance use challenges…

1. Do want to work:

   …sometimes just don't know where to start or cannot due to treatment requirements

2. Are able to work:

   ….as with any one, just getting a job is not enough. You want the right job for you.

3. Should work:

   …if you think working is stressful, try unemployment, social isolation and poverty!

The POWER of Peer Support

"When people do not see "recovery" as part of their lives, they need to be surrounded with possibilities of recovery."

(Building a Foundation for Recovery: A Community Education Guide on Establishing Medicaid-Funded Peer Support Services and a Trained Peer Workforce. DHHS Pub. No. (SMA) 05-8089. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.)

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A Person Fell in a Hole

A person experiencing emotional distress fell into a hole and couldn't get out.
A businessman went by. The person in the hole called out for help. The businessman threw him some money and told him, "Get yourself a ladder." But the person could not in this hole he was in.
A doctor walked by. The person said, "Help, I can't get out." The doctor gave him drugs "Take this, it will relieve the pain," The person in the hole said thanks, but when the pill was still stuck down there, all alone.
A renowned psychiatrist rode by and heard the person's cries for help. He stooped and did you get there? Were you born there? Were you put there by your parents? Tell me a yourself, it will alleviate your sense of loneliness." So the person talked with him for fift then the psychiatrist had to leave, but he said he'd be back next week. The person thank was still in his hole.
A priest came by. Again, the person in the hole called out for help. The priest gave him said I'll say a prayer for you. He got down on his knees and prayed, then left. The perso grateful; he read the Bible, but he was still stuck in that hole.
A Peer Mentor happened to be passing by. The person cried out, "Hey, help me, I'm stu hole."
Right away, the Peer Mentor jumped in the hole with him. The person in the hole said, "What are you doing? Now we're both stuck here." But the Peer Mentor said, "It's okay, been here before, and I know how to get out."

Among the benefits associated with peer support include:

improved self-esteem (Davidson et al., 2004)
increased satisfaction with care (Solomon & Draine, 1995)
improved engagement for traditionally alienated consumers (Rowe et al., 2007)
improved social functioning (Davidson et al., 2004)
increased access to resources and decreased stigma (Mowbray et al., 1998)
greater gain in well being (Campbell, 2004)
increased self-efficacy and enhanced employment (Van Tosh & del Vecchio, 2000).

"*creates culture change in every aspect of treatment. They can make recommendations for improving forms and assessments, conduct interviews or do surveys to obtain information regarding consumer satisfaction. Their ability to relate to service recipients creates safety for that person to express themselves, which allows professional staff to devote time in areas where they are more needed.* (Paving New Ground, Peers Integrated into In-Patient Settings)

Example: Peer Support

MH Consumer Providers:

- http://www.rand.org/pubs/technical_reports/2008/RAND_TR584.pdf

Gates & Akabas (2007). *Developing strategies to integrate peer providers into the staff of mental health agencies*

Carlson, Rapp & McDiarmid (2001). Hiring Consumer-providers: Barriers and alternative solutions

Boston University's *Systematic review of peer delivered services 1989-2009*

- http://www.bu.edu/cpr/repository/documents/pdf/campbell-leaver2003.pdf

Study	Design	Outcomes
Forchuk (2005). Therapeutic relationships: from psychiatric hospital to community, *Journal of Psychiatric and Mental Health Nursing 12(5),* 556–564.	Randomized Control Trial to determine the cost and effectiveness of a transitional discharge model (TDM) of care with clients who have a chronic mental illness. This model consisted of: (1) Peer support for 1 year and (2) Ongoing support from hospital staff until a therapeutic relationship was established with the community care provider. Participants (*n* = 390) were interviewed at discharge, 1 month post-discharge, 6 months post-discharge and 1 year post-discharge	Peer support transition program added to psychiatric hospital team had a decrease in the number of hospital days, reduction in readmission rates, increased discharge rates and an increase in quality of social relationships. Intervention subjects were discharged an average of 116 days earlier per person. Based on the hospital per diem rate this would be equivalent to $12M CDN hospital costs.
Clarke et al. (2000)	RCT Longitudinal impact of peer support on hospitalization rates	Individuals receiving peer integrated community support had longer community tenure, reduced need for hospital admission or emergency hospital care.
Min et al. (2007)	Longitudinal impact of peer support on hospitalization rates	Use of peer support resulted in longer community tenure as well as a decrease in hospitalization readmission over a 3 year period of time.

Study	Design	Outcome
Klein, A.R., Cnaan, R.A., & Whitecraft, J. (1998). Significance of peer social support with dually diagnosed clients: Findings from a pilot study. Research on Social Work Practice, 8(5), 529-551	Comparative study; 2 case management conditions: with peer support (n=10) and standard (n=51)	Clients of peer support had fewer inpatient days, better social functioning, and some quality of life improvement
Felton, C.J., Stastny, P., Shern, D.L., Blanch, A., Donahue, S.A., Knight, E., Brown, C. (1995). Consumers as peer specialists on intensive case management teams: Impact on client outcomes. Psychiatric Services, 46(10), 1037-1044	Controlled trial.	Greater improvement in satisfaction with living situations and finances, and fewer reported life problems than those in the non-user assistant group.
Dumont, J., & Jones, K. (2002). Findings from a consumer/survivor defined alternative to psychiatric hospitalization. Outlook, 4-6.	Experimental design studying Crisis Hostel compared to inpatient hospitalization with a 6 and 12 month follow up	Increased empowerment, quality of life (i.e. healing and satisfaction), and decreased hospital admission rates were associated with the Crisis Hostel alternative Participants receiving the peer delivered hostel residential service had better “healing outcomes” and greater empowerment. The experimental group had greater levels of service satisfaction and significantly lower psychiatric hospital costs.

Study	Design	Outcome
Kaufmann, C.L. (1995). The self help employment center: Some outcomes from the first year. Psychosocial Rehabilitation Journal, 18(4), 145-162.	Randomized controlled trial with 161 individuals assigned to control or experimental group. Outcomes measured in intervals of six months. Individuals assigned to the experimental group received a 5-stage model of intervention: a) engagement; 2) job skills training; 3) individual job seeking and support; 4) support; 5) graduate groups. Stages 1 and 2 were delivered by professionals and Stages 3, 4 and 5 were delivered by peers.	Results suggested no differences between groups at the 6 month follow-up (19% of experimental and 16% of control groups were working at a paid job for 16 hours per week or more) but were significant at the 12-month follow-up (19% of experimental and 7% of control were working at a paid job for 16 hours per week or more).
Lucksted, A., McNulty, K., Brayboy, L., & Forbes, C. (2009). Initial evaluation of the peer-to-peer program. Psychiatric Services, 60(), 250-253.	Pre-post design, including participants receiving peer-to-peer mentoring classes (a structured, experiential group aimed at empowerment, wellness, and relapse prevention)	Participants receiving a peer-to-peer showed significant positive gains in terms of self reported ability to manage their mental illness; their sense of confidence about their lives, and their and their sense of connection with others
Paulson et al. (1997-2000)	Randomized controlled trial; 3 conditions: assertive community treatment employing users (n=58), employing non-users (n=59), and usual care (n=61)	Clients of peer employees had a longer community tenure before hospital admission, fewer hospitalizations and need for emergency care

Study	Design	Outcome
Nelson, Ochocka, Janzen and Trainor (2006)	Comparison of active participation in drop-in center services versus non active participation at 18 months	Active participants had fewer emergency room visits and better quality of life. Significant differences were found in greater social support, greater instrumental role involvement and decreases in psychiatric hospitalization when examining changes from baseline to 18 months among active participants.
Campbell, J. (2004). Consumer-operated services program (COSP) multisite research initiative: Overview and preliminary findings.	Experimental study of a large (n=1,827) (COS) multisite study in which participants were randomly assigned to consumer-operated service programs using three models of services: drop-in, advocacy and education, and mutual support programs/groups. They also received their traditional mental health services. Those receiving COS services were compared to individuals who received only traditional mental health services.	Experimental participants showed greater improvement in well-being over the course of the study than participants randomly assigned to receive only traditional mental health services

Trauma Informed Environment: Hospital or Prison?

A lot of attention is being paid to the role of trauma in mental illness

Even more attention is being paid to the role of treatment in traumatizing or re-traumatizing people

Trauma-Informed Resources

- Bloom, S. (Summer/Fall 2002). Creating Sanctuary, *networks, p.1. Alexandria, VA: National Technical Assistance Center, National Association of State Mental Health Program Directors*
- Ford, J. (2003, January 17), *Trauma Adaptive Recovery Group Education and Therapy (TARGET). Retrieved from www.traumamatters.org/documents/TARGET-- JulianFord.pdf on January 17, 2003*
- Giller, Esther. (Spring 2005) *Sidran Bookshelf: Trauma and Dissociation. Information and Resource Newsletter, (listing of publications). On line: www.sidran.org*
- Harris, M. (1998). *Trauma recovery and empowerment: A clinician's guide for working with women in groups. New York, NY: The Free Press*
- Herman, J. (1992). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror. New York, NY: Basic Books*
- Hodas, G.R. (2004). *Understanding and responding to childhood trauma: Creating trauma informed care. Unpublished paper. Pennsylvania Office of Mental Health and Substance Abuse Service*
- Najavits, L. (2003, January 17). *Seeking safety. Retrieved from www.seekingsafety.org/3-02%20arts/training%20in%20SS-s.pdfZ*

Shared Decision Making

Shared Decision Making and Medication Management in the Recovery Process
Patricia E. Deegan, Ph.D. and Robert E. Drake, M.D., Ph.D. Psychiatric Services November 2006

http://www.patdeegan.com/commonground/research

Dignity of Risk
http://www.thecouncil.org/base.aspx?id=614&cat=29&sec=r

In 2006, 24 community psychiatrists identified 12 barriers and 22 solutions to promoting recovery within their profession

Dr. Mark Ragins, MD
"Medical Collaboration"

"In medical school, I was taught to be a strong, helping professional, ordering medication for weak, helpless, dependent, sick patients, and then assessing their "compliance" with my regimen…. to advance recovery, I had to discard my white coat, my coat and tie, and even my professional distance."

“My role with medication has become that of a consultant. I listen to what members say helps them, educate them about their conditions and medications, and, as much as possible, prescribe the medications, they choose and then assess with them the results of our “collaboration….This is a rehabilitation/recovery model instead of an illness/treatment model.”

Dr. Ron Diamond, MD

Traditional Approach to Medication

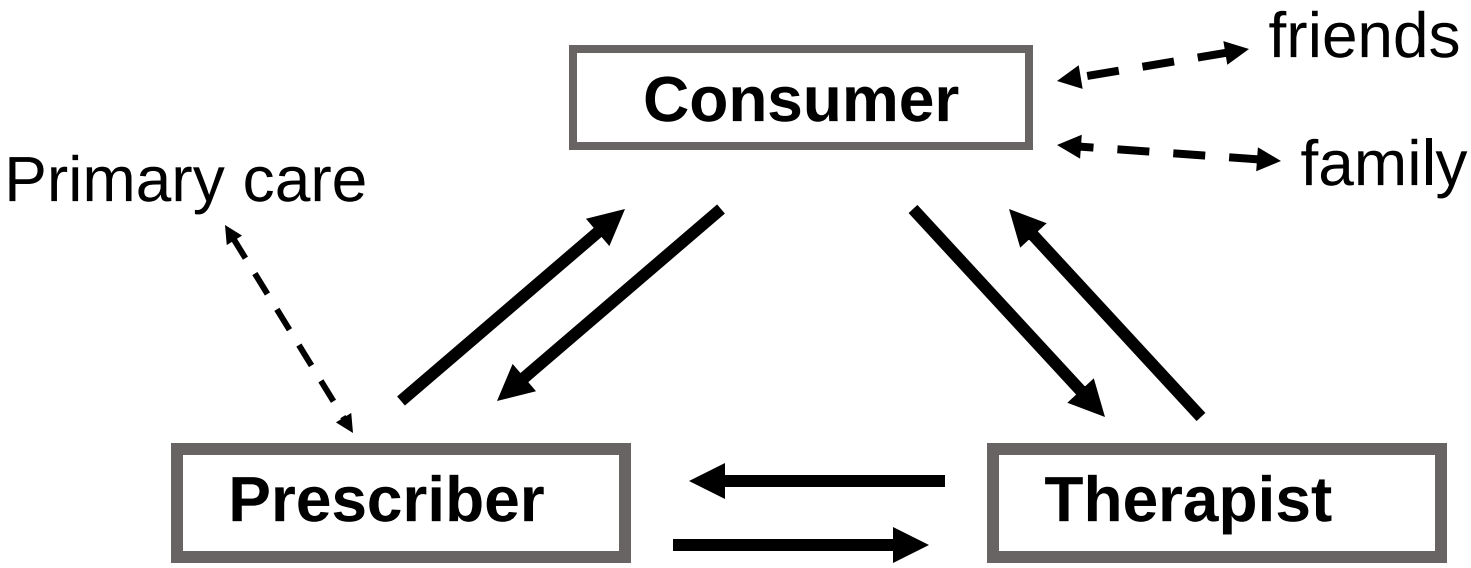
- Start with accurate diagnosis.
- Inform patient about the role of medication in treating the condition.
- Engage the patient regarding the need for medication adherence.
- Patient input is necessary, but prescriber's expertise is most critical.

Recovery Approach for Medication

- Medication is neither “good” nor “bad,” but merely a tool that can address certain kinds of problems.
- Work with consumer to jointly understand the nature and impact of the problem.
- Work together to determine which solutions have been tried, what has worked, and what has not.
- Consider if medications would be a useful way to address some part of the problem.
- The prescriber has the most expertise about the medication; the consumer has the most expertise about the problem.

- The issue is not “compliance” or “adherence.”
- The issue is ***effectiveness.***
  - Is this medication being used in the most helpful way for dealing with the problem while causing the least risk and side effect burden?
- A consumer may choose to use medication other than as prescribed. This is a ***decision,*** not an error.
  - What has gone into the consumer’s decision?
  - Respectful curiosity is helpful; lecturing is not.

In a Collaboration, We Are All “In Charge”



Who makes which decisions?

Medication

- Medication is NEVER a goal of treatment.
- Medication is a tool to help the consumer reach his or her goals.
- Medication always has a “meaning” that may be as important as pharmacology.
- Ambivalence about medication is normal.
- People *will* take medication if they feel it will help them.
- … and *will not* take medication if they feel it will not help.

Taking Medication Regularly

- Beliefs are important
  - About the problem
  - About the solution
  - About whether medication will help
- Relationships are important
  - We take medication from people we trust
- Hope is important: Why do anything if you feel it will not help and your life cannot get better?

Life View Without Recovery Focus

Dr. Keris Jän Myrick

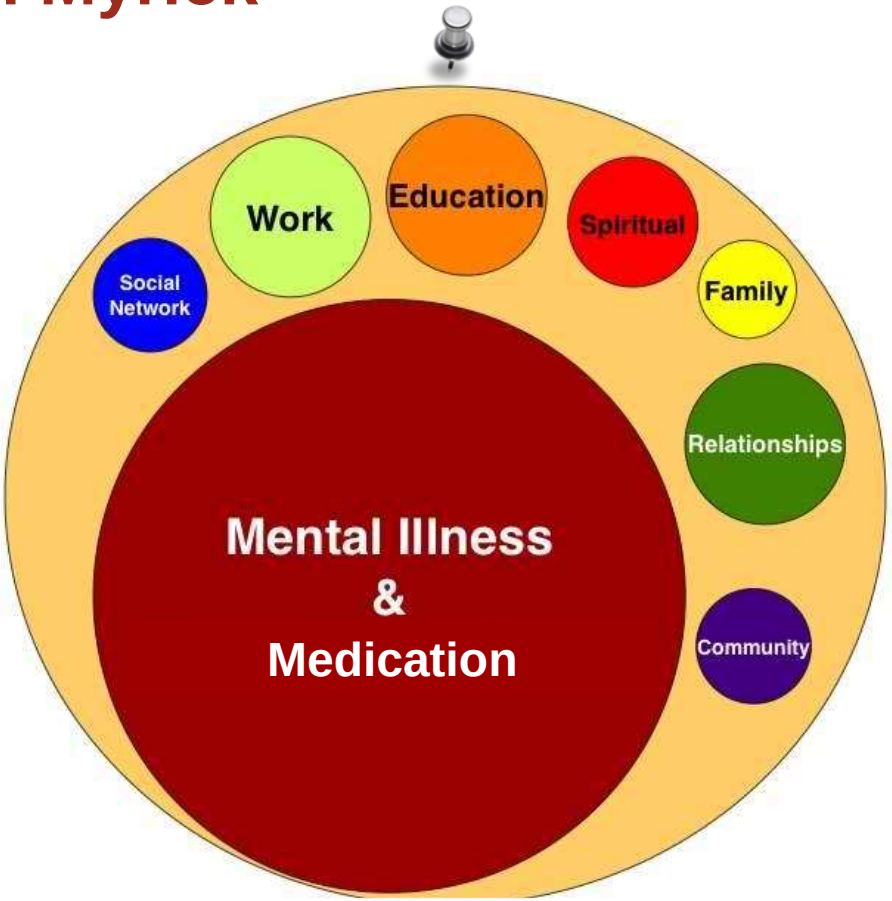


Image: Diagram of “life view” without recovery focus

Life View With Recovery Focus

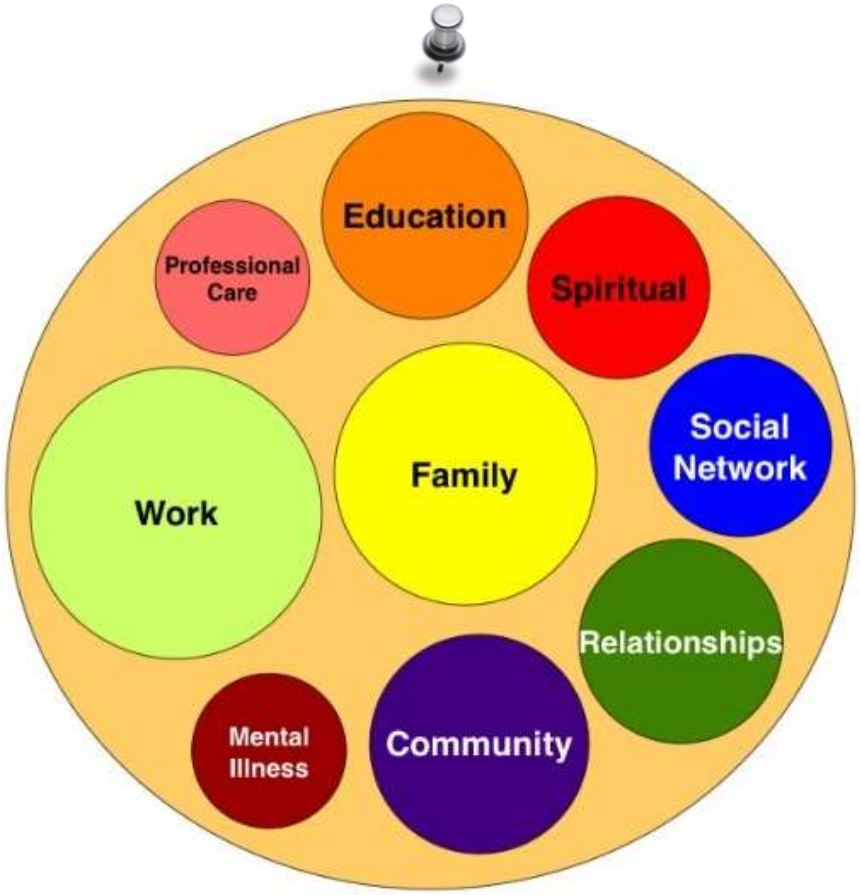


Image: Diagram of “life view” with recovery focus

Shifting Our Focus

- from “illness” to WELLNESS and the Whole Person

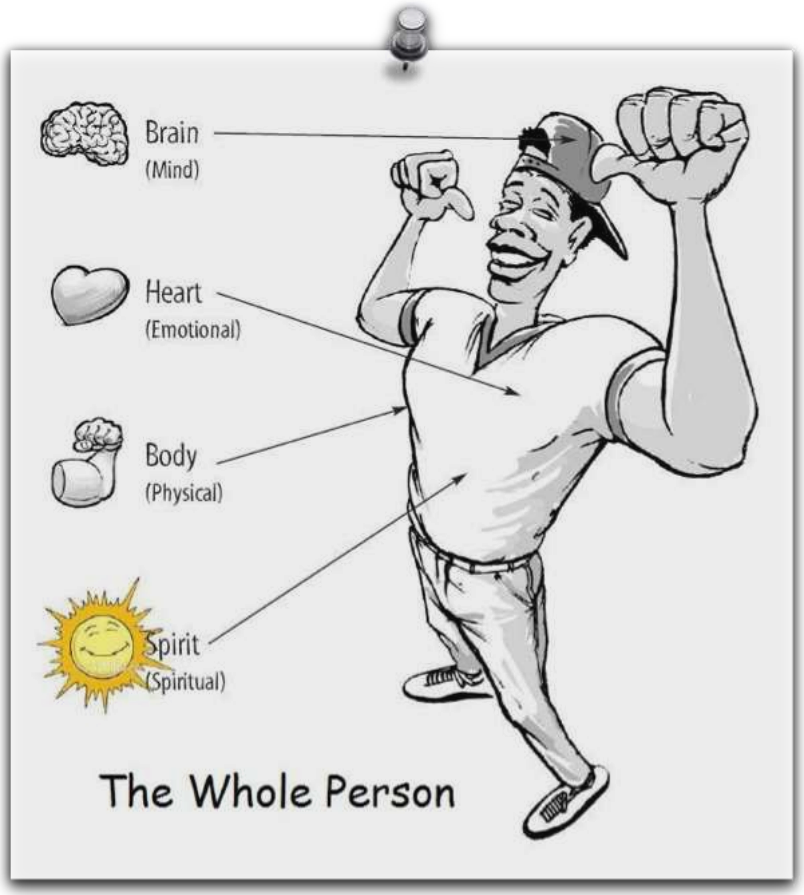


Image: Poster of “The Whole Person”

Definition: Wellness Self Management

1. Feeling a sense of control over your life and your future, including control over your mental wellness;
2. Learning and practicing ways to effectively respond to life's challenges including physical and mental health issues;
3. Developing resiliency and reducing likelihood for relapse or re-hospitalization
4. Using self-care to enhance your mental and emotional wellness

Studies show that self-management of wellness facilitates recovery from mental illnesses. This is no different from a person learning how to manage diabetes or high cholesterol. It is about learning how it impacts you, what makes it worse, what makes it better, and applying the things that work for you.

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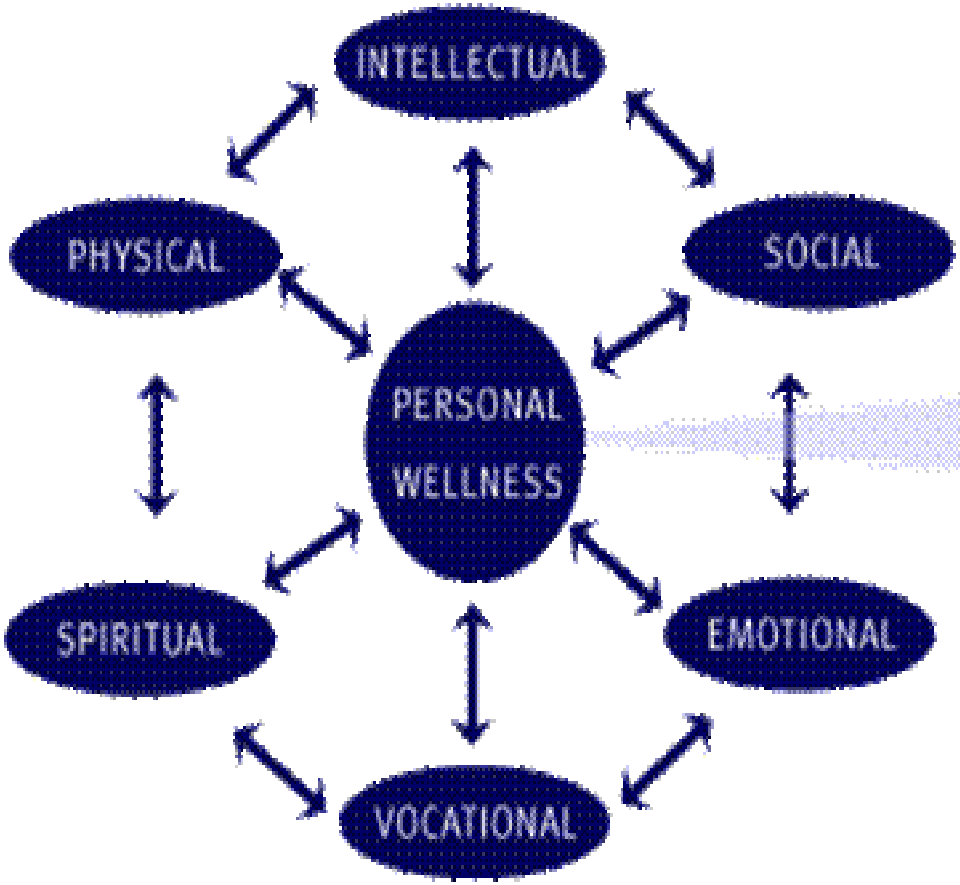
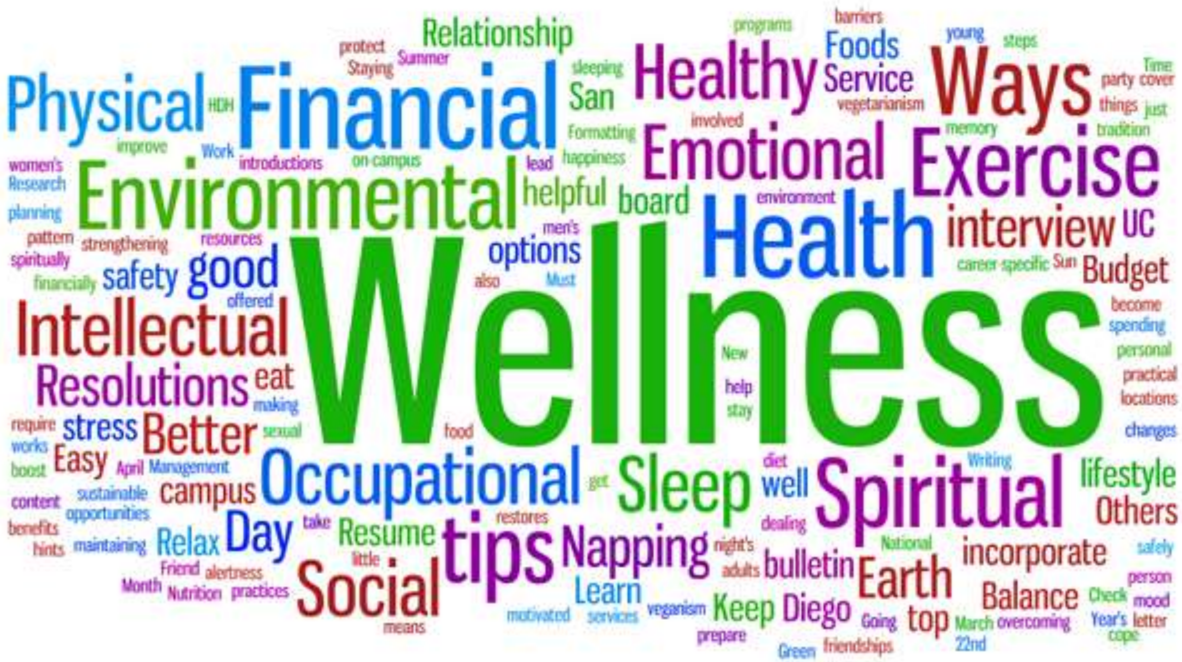


Personal Wellness:

- Self Responsibility
- Optimism
- Self-Directed Approach
- Self Efficacy
- Choices

Montague, 1994



Relationship
protect
Staying
Summer
programs
barriers
young
steps
Physical
HDH
Financial
sleeping
San
Healthy
Foods
Service
Ways
Time
party
cover
things
just
vegetarianism
involved
memory
tradition
improve
Work
introductions
on-campus
Formatting
happiness
lead
Emotional
Exercise
women's
Research
planning
Environmental
helpful
board
environment
Health
interview
UC
pattern
strengthening
resources
men's
options
spiritually
safety
good
career
specific
Sun
Budget
financially
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also
Must
Wellness
become
spending
Intellectual
New
personal
practical
Resolutions
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Writing
Occupational
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Sleep
well
Spiritual
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Others
benefits
hints
maintaining
Relax
Day
take
Resume
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tips
Napping
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adults
bulletin
National
Earth
incorporate
safely
Friend
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Nutrition
practices
Social
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Balance
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services
veganism
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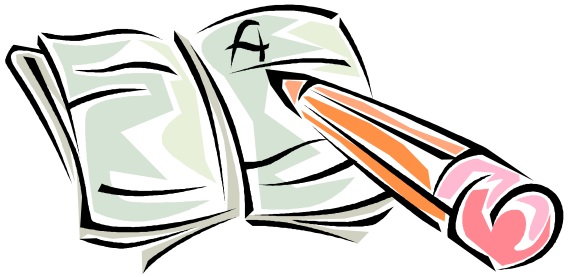
friendships

The Wellness Self-Management Workbook



Recovery-Based Practices

Person-Driven, Strengths based

Natural support networks

Relationships

Recovery-based Assessments

Holistic- life domains

Family support/education

Culturally competent

Trauma informed

Mental health/substance use/ physical health integration

Eliminating seclusion and restraint

Minimizing coercive interventions

Individualized Crisis Planning

Appropriate and effective use of psychopharmacology

Home rather than housing

Community-based (social capital)

Personal Planning

Employment as a path to recovery

Self-help, mutual aid, peer education

Access to effective interventions

Access to EB and Promising Practices

Cognitive behavioral therapy

Dialectical behavioral therapy

Trauma-specific treatment and support

Family Psychoeducation

Supported Housing, Employment and Education

Integrated Dual Disorders Treatment

Individualized Placement and Support

Consumer-run organizations

Assertive Community Treatment

ICCD Clubhouse

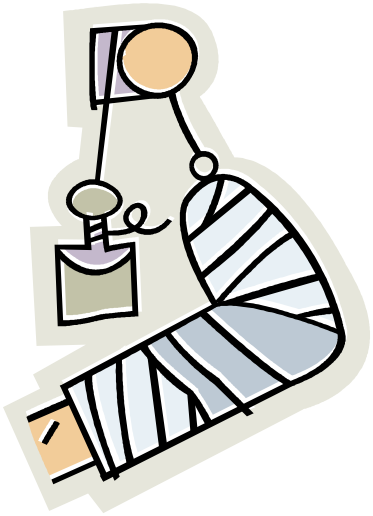
Wellness Management and Recovery

Seeking Safety

Motivational Interviewing

Shared Decision Making

Consumer operated services



CQL Brown Bag Recovery Lunch and Learn Series

Wednesday, May 6th	What is Recovery?
Wednesday, July 1st	Wellness Planning and Recovery Tools
Wednesday, August 5	The Role of Employment in Wellness and Recovery
Wednesday, Sept 2nd	POM in Recovery (CQL behavioral health supplemental tool)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