With money attached to recovery transformation every advocate wanted to make sure that their particular vision of recovery was the one that would be funded and every mental health program director and worker wanted to define what they were already doing as recovery so they could get more funding to support their programs and jobs. Power struggles began to emerge everywhere.

Personally, I began spending less time developing my own ideas in relative isolation and more time in workshops and meetings sharing with other people who had their own cherished ideas about recovery.

As a result, I created a new opening for my "Introduction to Recovery" presentation that begins by asking why recovery has become the new standard: "Who died and left recovery King?" My answer was, "Because a lot of different passionate people with big mouths have been pushing it." I go on to openly acknowledged a variety of contributing roots of the recovery movement – 12 step, consumer movement both angry advocates and collaborative coworkers, psychiatric and psychosocial rehabilitation, staff who don't like following rules and work with a variety of people on the fringe including homeless, jail diversion, non-compliant, and dually diagnosed people – and I've even added two groups who haven't been advocating openly, but I think will sustain the movement – staff working in the field for personal reasons and staff who in the Moral Treatment tradition think they're doing God's work. I close this opening by pointing out that each of these groups has different ideas about recovery and that we need everyone to stay involved if we're going to achieve transformation. No one group can "win." "All of us don't have to be in agreement, but we have to be in alignment moving the same direction." Or more poetically, "We don't have to all be singing the same note, but we have to be harmonizing the same chords and melody."

The problem is that we still need a compelling, practical definition of recovery to build on (and to based funding decisions on). This paper is my effort to create a practical, consensus driven definition of a recovery culture.

Defining a Recovery Culture

(2005)

Recovery is gaining serious momentum and being pushed on generally ambivalent systems, programs and people to be implemented by outside forces like congressional committees, presidential reports and us. Efforts to this point have focused on promoting belief in recovery as a possibility by sharing first person accounts of recovery, research data about its existence, and some efforts to describe the paths to recovery (My "4 stages" is one of a number of well regarded examples.) The next stage is also underway defining and training in practices that promote recovery (e.g. illness management, consumer staffing, supportive employment, Wellness Recovery Action Plan (WRAP), rehabilitative goal setting, self-help, psycho-education, community integration, Assertive Community Treatment (ACT), medication collaboration, supportive housing, etc.). Unfortunately, the culture that these practices are being disseminated through is increasingly the "evidenced-based culture", another version of the medical culture that recovery is seeking to change. It is unlikely that the results of putting a few recovery-based practices within a medical culture to satisfy outside pressures will be the creation of successful recovery-

based programs. Increasingly, we are seeing the need to work directly with defining and training recovery-oriented cultures and leadership in order to create a fertile soil for the seeds of recovery to grow in.

Defining a recovery culture at this point of our development depends a lot on who you're talking to. One of the reasons for recovery's present momentum is that multiple forces are coming together under the same banner, but they have different perspectives. In brief, there are 4 major forces:

(1) Consumers – They value consumer participation personally, programmatically, and politically ("nothing about us without us"). Empowerment, wide spread consumer staff, focusing on people instead of illnesses, choice, consumer satisfaction, breaking down barriers between staff and consumers, quality-of-life opportunities (housing, employment, education, etc.), and respect as an anti-stigma tool ("stigma can be more disabling than symptoms") are their focus.

(2) Rehabilitation services – They value increasing people's functioning and participating in our community in meaningful roles even if there are still symptoms. Training programs, rehabilitative goal setting, supported quality-of-life services, role creation, coaching, and consumer motivation are their focus.

(3) Psychiatrists and the professional community – They are often seen as obstacles to recovery implementation, but a subset have been energetic in promoting a recovery oriented illness management model. Understanding illnesses, triggers, medications, stress management and coping skills; building protective social networks, family and consumer psycho-education, intensive staff supervision and support (ACT), and crisis alternatives to hospitalizations; implementing "best practices", reimbursement parity, and reducing symptoms and their impact are their focus.

(4) Social and political systems – They want to impact the social and political costs of people with mental illnesses. Reducing dangerousness, homelessness, incarceration, hospitalizations and other social costs, integrating substance abuse consumers, reaching out to unserved people, and collecting quality-of-life data to assess accountability and efficiency are their values.

While these perspectives are clearly not contradictory of each other - in fact they are highly synergistic - it is rare for them to be integrated. Generally, people are only seeing their own priorities. A common result is less effective, fragments of recovery (e.g. a supportive employment program using an outside, unsupportive psychiatrist; a consumer program that excludes crisis or hospital interventions and loses credibility when they send away people in crisis; a coping skills class without consumer staff as models; a homeless outreach program without medications, substance abuse treatment, or trauma therapy).

As a field we are only beginning to integrate these values into a full recovery culture. Here is an attempt to describe elements of an integrated recovery culture for a "readiness inventory":

(1) High inclusion of consumers: There are numerous consumer staff not just in special consumer jobs. There are reduced "us vs. them" distinctions and lowered boundaries between staff and consumers (e.g. shared bathrooms, work areas, meetings, hard to tell who the staff and consumers are). Safety is based on "community watch" rather than separating and forcibly guarding consumers. There are widespread

consumer choices including input into goals, treatment plans, and program services. Consumers have multiple roles besides treatment recipient. Staff uses respectful, non-stigmatizing language.

(2) Leadership and administration that treats the staff the way we want them to treat the consumers: They emphasizing staff hope, empowerment, responsibility (giving them control over some funds, choices, "high risk-high support"), and meaningful roles. They encourage staff to take on multiple roles besides professional, so that consumers can take on multiple roles besides patient, encouraging lots of individual expressiveness. They value every staff as an expert in something. They encourage staff to be emotionally expressive and open about themselves with consumers and each other.

(3) Creating a counter-culture of acceptance: There is an ability to welcome and include difficult, socially undesirable, noncompliant people. There are "no fail" rules, outreach to dropouts, and efforts minimize "lost to follow-up". Engagement includes charity as well as treatment. There is minimal coercion, rules to follow, exclusions, and "hoops to jump through". Staff is widely accessibility both inside and outside building and after hours. Consumers have the ability to make individualized, collaborative plans. Staff is willing to engage in emotional, "real" relationships with consumers instead of keeping them at a "professional distance". Staff has a subjective awareness of what the consumer is going through and feels like.

(4) Holistic, integrated care focused on the person, not just their illness: Treatment plans, services, and outcome measurements focus on quality-of-life. Staff is organized into teams with overlapping parts, not separate specializations. There are limited "it's not part of my job" restrictions of staff activity. There is actual collaboration with other social agencies (Social Security, Section 8, Vocational Rehabilitation, Children's Services, probation and parole) rather than merely referrals. There is an integration of substance abuse treatment for every staff and program. Staff is knowledgeable about people's life situations, not just their diagnosis. Staff "does whatever it takes".

(5) High utilization of rehabilitative, recovery, and illness management techniques within a conscious framework of recovery promotion: Regardless of funding availability, there is a prioritization of these services (supportive housing, employment, education, training, coaching, illness self-management, psycho-education, ACT) rather than offering them only after adequate clinical services are available. Staff has a working knowledge of recovery stages, goals, and individuals' progress (e.g. they know the answer to "What is the rehabilitation value of this activity?").

Many of these elements can be further delineated and even measured to create a recovery readiness inventory tool.