

CHAPTER 26

RECOVERY AND COMMUNITY MENTAL HEALTH

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This chapter is intended to introduce and clarify the concept of recovery, the revolutionary qualities of the recovery movement, the what and how of recovery-oriented services, and how mental health organizations can and should transform to become compatible with recovery principles. The recovery movement has emerged with much energy and enthusiasm in community-based mental health programs throughout the United States and around the world. Recovery brings hopeful, value-based transformational concepts and practical skills to effectively serve people who have been difficult to serve and whose experience with the treatment system has left them frustrated, demoralized, and alienated.

The following case description, which is interspersed throughout the chapter, will be used to demonstrate key points about these challenges and the various responses to them.

CASE EXAMPLE

Robert served in the army in Korea, but long after the fighting was done. He mainly remembered using drugs sold to him by his sergeant. When he left the military, he was lost, confused, isolated, using drugs, and increasingly wrapped up in a religious guilt feeling that God was punishing him. He wandered the country and became suicidal. He went to a Midwestern Veterans Administration hospital for help, but was locked in a barren ward, deprived of any means to hurt himself. After two weeks, he promised not to kill himself, so they let him out. He hated the experience and never returned to the VA for any services or benefits.

He spent the next decade traveling around, doing odd jobs and learning some construction skills. Occasionally homeless, he often lived in hotels or shelters as he moved about. He never held a steady job or an apartment of his own, and had no long-term relationships or connections with his family.

Then a terrifying thing happened. He fell asleep on a bus and two undercover military agents sat behind him and implanted a receptor in his head so they could transmit satellite messages to him. These messages were very disturbing and crazy-making, telling him to kill himself or hurt other people, especially black people. When he saw a newspaper report that his old sergeant had been made a general, it all made sense to him. He was being discredited so he could never testify against his old sergeant.

He went to hospitals to get X-rays to find the implant and remove it, but instead was told he was crazy. He was given medications that confused him. He felt unable to “fight the machine.” He struggled mightily against these messages, but sometimes did attack people. He developed headaches, severe anxiety, and insomnia. He learned that alcohol calmed him and helped him sleep, but also dulled his mind and reduced his vigilance. Speed seemed to work better, because it helped him think fast enough to outsmart the machine, but then the headaches, insomnia, and anxiety returned. He isolated himself to avoid hurting anyone, and ended up living under a bridge.

Our discussion begins by comparing and contrasting the two most common mental health treatment models—the medical model and the rehabilitation model—with the recovery model.

The *medical model* is predicated on the notion of diagnosing psychiatric illnesses, treating their symptoms, and helping persons with these conditions return to health and more productive and meaningful lives. However, it is a paradigm that fails to address some concerns for persons with mental illnesses. Many people with mental illnesses do not agree that they have an illness, at least not in the way it is defined by the medical model, and they are often difficult to engage in treatment. Even with excellent treatment, many do not experience sufficient symptom relief from treatment alone to feel healthy enough to return to life. After most symptoms are relieved, many continue to have substantial disabilities from other factors (e.g., trauma and loss, personality issues, low intelligence, poor relationship skills, poverty, lack of education, social ostracism), not to mention the immediate and longer-term impacts of involuntary and coerced treatment interventions. This leads many to seek additional, often equally insufficient, medical treatments and/or to give up on the mental health system entirely.

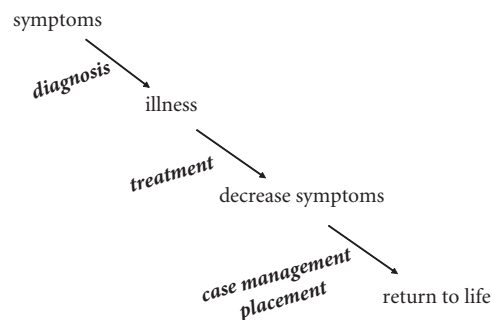


Figure 26.1 Medical Model

ROBERT'S MEDICAL MODEL SCENARIO

Robert was hospitalized and was diagnosed with a co-occurring mental illness and addiction disorder. The hospital staff explained to him in a compassionate, psychoeducational manner that there wasn't any machine. They explained that he had a chemical imbalance in his brain, probably exacerbated by substance use. The brain disorder was causing his mind to misperceive reality, and the "machine" was a delusion. The good news was that medications could restore his brain's chemical imbalance so he wouldn't be delusional anymore.

Unfortunately, Robert refused to believe this explanatory model, even though the staff were kind and compassionate. He refused the medications and never went to the outpatient clinic they referred him to. Since Robert lacked insight and was struggling to meet his basic needs, he was repeatedly hospitalized on an involuntarily basis and forcibly medicated. When not hospitalized and removed from society for his protection and public safety, he would often return to a life of alienation, homelessness, loneliness, and little hope of returning to a productive life.

The *rehabilitation model* focuses more on functioning than on symptoms. A functional assessment leads to training to reduce deficits and build strengths. When persons are sufficiently supported and perceived as likely to succeed, they are assisted in using their new and restored skills to return to life. However, this model also fails for a significant number of people. It is almost always used sequentially with the medical model, based on the presumption that symptoms must be treated and stabilized before skills training and support efforts would be effective. If symptoms cannot be controlled, such people are often deemed not ready for rehabilitation. This vulnerability is being actively addressed with various supportive rehabilitation techniques (e.g., supported employment, housing, education). The need for symptom control is not necessarily a prerequisite for effective functioning, but our system often reflects social stigma and rejection by not giving people with overt symptoms a chance to build functioning. The rehabilitation model depends on sufficient opportunity: that if someone has job skills, there is a job available, or if someone is able

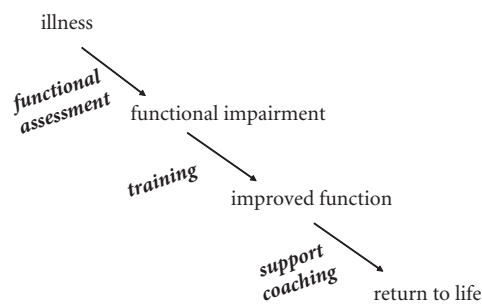


Figure 26.2 Rehabilitation Model

to live independently, there is an affordable apartment available. To be effective, rehabilitation has to be supplemented by community development to build such opportunities.

ROBERT'S REHABILITATION SCENARIO

After he was discharged from the hospital, the outpatient rehabilitation program staff told Robert that they would help him with supportive housing and employment after he was stabilized. When he became compliant with medications (by taking medications) and maintained sobriety (by completing a drug treatment program), he would be ready for rehabilitation. Alternatively, if he felt that such an approach was too difficult, they would help him get on Social Security disability. They would then offer him housing and services in a residential program where he would receive the treatment, structure, and supervision that he needed until he could again function safely and independently. When offered these choices, he refused all services and eventually wandered off and out of contact with the treatment program.

The recovery model emphasizes changes that persons make in and for themselves. When people first come for services, they often feel their illness has swallowed them up. They have struggled to overcome it on their own for quite a while, but with little success. They have experienced substantial loss, destruction, and rejection, as well as self-doubt. They often feel crippled by the illness and their life is a constant all-consuming struggle. Recovery engages the part of the person that is struggling, that may still have hopes and dreams, and aligns with that part. The recovery approach helps by decreasing the impact of the illness and by restoring or expanding the rest of the person's life. Recovery requires building meaningful roles in life.

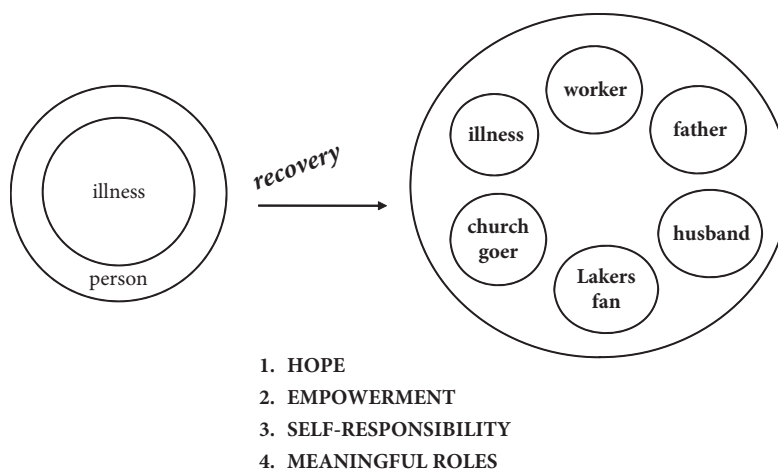


Figure 26.3 Recovery Model

ROBERT'S RECOVERY SCENARIO

The staff guided Robert toward recovery step by step. They helped him rebuild hope by having him work with an outreach worker who used to be homeless and hopeless himself. "If I could make it, so can you." They helped him create an image of a better future dealing with the "implant" and other frightening thoughts and to get back to work. They helped to empower him and build up his belief in himself. They gave him self-help coping tools, including medications he could manage and administer himself. They insisted on his taking responsibility for not hurting anyone, no matter what the "satellite" or other entities would tell him. They invited him to contribute to their program in meaningful ways, making lunches for homeless people and earning money to pay rent. As he struggled to rebuild, they stuck with him to find ways to overcome the barriers that emerged.

Recovery is both a destination and a journey. Meaningful goals mark progress along the way:

1. Functions may be recovered—the ability to read, to sleep restfully, to work, to have coherent conversations, to make love, to raise children, to drive a car, etc.
2. External things may be recovered—an apartment, a job, friends, playing in a band, a spouse, a car, family relationships, a TV, educational programs, etc.
3. Internal states can be recovered—feeling good about oneself, satisfaction, self-confidence, spiritual peace, self-responsibility, a sense of identity other than as a mentally ill person, etc.

The journey of recovery is a very personal process. In the same way that Elizabeth Kübler-Ross described a set of stages that people go through as they struggle with impending death, Mark Ragins described a set of stages (hope, empowerment, self responsibility, and achieving meaningful roles) that people go through as they struggle to overcome serious mental illnesses (Ragins, 2002). Even as hospice has been developed to assist people in their journey to die with dignity, mental health is developing recovery-based programs to assist people in their journeys to live with dignity.

We will return to Robert and more details of what happened to him, later in the chapter.

THE RECOVERY REVOLUTION

In his book *The Structure of Scientific Revolutions*, Thomas Kuhn describes the process of revolutionary change in science as resulting from the failure of a dominant paradigm to explain or address the issues for which it was originally intended. A scientific revolution is a "non-cumulative developmental episode in which an older paradigm is replaced in whole or in part by an incompatible new one." Such a change is analogous to a political revolution.

The conditions that have led to the current "revolution" to transform the mental health system to accommodate the notion of recovery clearly match those described by Kuhn. Persons

who had been recipients of mental health services came to feel that they were not getting better, would complain that their needs were frustrated or unmet, and often felt harmed by the system that was allegedly there to help them. They also went in and out of the system (or avoided it because of the negative experiences they had grown accustomed to) into other niches of society that were neither prepared for nor able to deal with them, reflecting the failure of the mental health system; for example, jails and prisons, safety-net health clinics, or the streets. As more persons with lived experiences in the mental health system shared their stories with peers and members of their social and support networks, a growing sense emerged that things had to change and that alternative approaches must be developed (Davidson et al., 2010; Spaniol & Koehler, 1994; Warner, 1985; Becker and Drake 2003).

Over the past 20 to 30 years, the recovery movement has progressed from being an outsider revolutionary movement to being an insider reform movement. This has been a difficult personal and tactical progression for many people in the movement. Angry advocacy is easier and more immediately satisfying than collaborative compromise. Criticizing is easier than constructive collaboration. Nonetheless, the shift is occurring, supported by a growing army of consumers, advocates, clinicians, policy makers, and influential community members. As the recovery movement has progressed, new challenges and applications have emerged. The full implications and impact of recovery are ahead of us.

Malcolm Gladwell, in *The Tipping Point* (2000), has hypothesized that a number of factors are essential for revolutionary ideas to become fully realized. These include:

1. **The Power of Context:** This is the realization that maintaining the status quo or incremental change is unsustainable and will fail, leading to system collapse and much worse outcomes. The evidence is mounting that the current paradigm is failing:
 - Many persons do not get better with traditional medical or rehab treatment approaches.
 - Many have become alienated from the mental health system and its coercive and sometimes harmful interventions.
 - For many who remain in the mental health system, the illness has become their identity and their lives are filled with hopelessness and passivity.
 - Unrecognized trauma has emerged as a major issue, but the system often fails to help without triggering old traumatic feelings or creating new ones.
 - The mental health system fails to recognize that many persons have significant strengths, want to take on more self-responsibility, and want to go on with their lives in the “real world.”
 - Budgets for mental health services have been slashed and often disproportionately allocated to more intense forms of treatment.
 - The lack of meaningful community support contributes to more trans-institutionalization of persons with mental illnesses into the criminal justice system.
 - The lack of a welcoming and caring system results in horror stories about persons with mental illness behaving in violent ways in the popular press (even though they are much more often the victims of various forms of brutal behavior), leading to more stigma and demands that we “lock up the mentally ill.”

When these failures of the usual care become more widely observed, the system is undeniably destabilized, and a new paradigm must emerge.

2. **The Power of the Few:** This entails developing and supporting connectors, mavens, and salesmen. Passionate and assertive champions who advocate for change make such changes happen. The primary instigators of the recovery movement have come from the consumer/survivor movement. These are people who describe themselves as having survived not only their mental illnesses, but also the traditional treatment for those illnesses. They angrily and painfully describe traumatic experiences associated with coerced treatment, institutionalization, restraints, and excessive medications, as well as social ostracism, stigma, and isolation. They actively promote system transformation through real consumer inclusion—“nothing about us without us,” including choice, empowerment, increased opportunities, decreased stigma, and direct participation in all aspects of the mental health system. Over time, the recovery movement has found champions scattered throughout the field, including the 12-Step recovery movement, rehabilitation professionals, civil rights advocates, staff “doing whatever it takes” with challenging populations like homeless people, transitional-age youth, and minority cultures, and spiritually based treatment providers. Many mental health professionals have found recovery practice a return to their core personal and professional values. Many have been doing recovery-oriented practice already, although sometimes “in the closet.”
3. **The “Stickiness” Factor:** This means compelling ideas presented in unconventional and unexpected ways and contrary to conventional wisdom. Approaches that attract attention and interest, that are “sticky,” involve imagining a dramatically new vision of what we do and how we do it. Our system has incorporated a pervasive view that serious mental illnesses are chronic and deteriorating. The default position is that most people with serious mental illnesses have impaired insight, poor judgment, lack of self-responsibility, and overall inability to function effectively in society. This view stresses stabilization of symptoms, which leads to controlling and coercive interventions, lifelong social isolation, and dependency.

Two sets of data sharply challenge this “default” position: First, longitudinal outcome studies of persons with schizophrenia have shown that many have been able to substantially recover. (7,8,9). Second, there is an overwhelming number and variety of first-person accounts of persons who have achieved recovery from major mental illness. More and more people are “coming out of the closet,” including celebrities, mental health professionals, leading citizens, and ordinary people everywhere, and they are sharing their stories of successful struggle and hope (Balter & Katz, 1987; Chamberlin, 1988; Saks, 2008; Jamison, 1997).

Unfortunately, both the longitudinal data and the personal stories of recovery have failed to gain much attention within the professional clinical consciousness. Actively counteracting these hopeful views has been the “clinician’s illusion” that the worst outcomes are typical and to be expected, often based on the skewed experience that many clinicians have had in their training or in the failing systems in which they work; in other words, a self-reinforcing conclusion, or what Gerald Caplan would call “theme interference.” (Caplan & Caplan, 1993). In recent years, this negative expectation has been increasingly replaced by the more hopeful and positively reinforcing vision that the outcome studies and personal accounts imply. The emerging descriptions of recovery have a compelling power that has attracted and inspired many people.

WHAT IS RECOVERY AND HOW DO WE MAKE IT PRACTICAL?

Recovery has been variably defined, which can be very confusing. However, some consensus was achieved in two recent initiatives.

The President's New Freedom Commission on Mental Health created a plan to transform the entire mental health system refocusing it on recovery," and declared that

recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.

In 2004, SAMSHA convened a panel of professionals, consumers, and families who agreed that "*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." They described 10 fundamental components of recovery: "Self direction, individualized and person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, responsibility, and hope." (National Consensus Statement on Mental Health Recovery, 2004)

In 2011, SAMSHA went a step further, bringing together mental health and substance abuse representatives to create a unifying Working Definition of Recovery: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" with four major dimensions—health, home, purpose, and community (SAMSHA, 2012).

Recovery is not the same as cure. For acute illnesses, recovery often results from symptom elimination and cure, but for persistent illnesses, recovery more often results from:

- Achieving self-management of the illness
- Maintaining hope and self-image
- Carrying on with life through rehabilitation and adaptation
- Replacing professional supports with natural supports
- Building strengths and resilience to handle future illness

Many people, including consumers, families, staff, and our communities, will be reluctant to give up the path of pursuing a medical cure for mental illnesses, but if taken together, those objectives offer us a realistic, practical route to recovery for almost everyone.

Successful recovery does not conclude with the person thanking the treatment providers for all their great understanding and help, but also remaining dependent upon them: "I'm so glad I met you. You really understand me. You gave me the right medications. You took care of everything. I know I can always rely on you to solve any problem for me. I'm going to stay in treatment with you and count on you forever because I'll never be well enough to handle things on my own." Instead, successful recovery leads to more self-knowledge and self-reliance: "I wouldn't have wished this illness on my worst enemy. The pain and suffering have been enormous, but in a strange way it has been a blessing in disguise. I've found and developed strengths I never knew

I had. I've learned what's really important in life. There have been deep gifts from my deepest wounds. It's made me into the person I am today." To get to that endpoint, we must change our initial response from, "You did the right thing coming to see me. I'm a good doctor. I'm going to be able to help you," to "I can already see strengths you are going to use to overcome this terrible illness." The hope in recovery is that they will develop, not that we will "cure" them.

HOW DO RECOVERY-BASED SERVICES WORK?

1. Recovery-based services are "person-centered" instead of "illness-centered."

A homeless outreach worker, himself a veteran with a history of mental illness and alcoholism, began stopping by Robert's encampment, bringing him sack lunches, sharing stories, and listening quietly. After several months, Robert agreed to come into a drop-in center to shower and get some clean clothes.

After another week, Robert was introduced to the team psychiatrist, to "see if our doctor can help you." As he listened to Robert's story, the doctor didn't ask many diagnostic questions. He asked Robert about the story of his life instead of the history of his illness. He learned that Robert was a very moral man, that he missed working, and that he was getting sick and tired of living on the streets. When the psychiatrist shared pictures of his own family, Robert said that he still hoped he could marry and have a family some day. Rather than providing corrective insights that "the machine" wasn't real and that he had a psychotic disorder that would probably respond to medication, the doctor met Robert where he was. He said he knew nothing about military satellite technology, but a lot about strengthening brains and dealing with overwhelming stressors. He was interested in Robert's efforts to strengthen his brain with alcohol and amphetamines and thought he could offer a better alternative. He offered him a prescription for a pill that "combines the effects of alcohol and speed that might calm you and focus your thinking. Would you be willing to try it instead of alcohol and speed to see if that helped you fight the machine better?" He agreed.

Put simply, the goal of recovery is not to treat mental illnesses, but to help people with mental illnesses to have better lives. However, this transformative approach ultimately affects the entire clinical process.

2. Recovery-based services are built on consumer strengths, leading to resilience, rather than on the clinical mastery of the professional treating the consumer's deficits.

The psychiatrist told Robert that he was more vulnerable to the "machine" by staying alone under the bridge than in a hotel room, and that he'd probably cope better if he was doing something positive instead of sitting worrying about this

all day long. To take advantage of his work ethic, Robert was offered “work for a day—house for a day.” He could work two hours a day in the program’s café lunch-room making hamburgers and sandwiches to earn a nightly hotel voucher. He was assured there would be people there who could help if he felt overwhelmed or violent and who wouldn’t lock him up. They began working together on his goal of fighting off the machine and rejoining society. They invited him to become a member of the community program (The Village).

Over the next few months, he improved. The machine quieted down enough so he could relax and sleep; the headaches went away. When he worked, the machine didn’t affect him at all. He began driving the van on catering jobs. The program staff were encouraged and offered him a permanent job and help getting a subsidized apartment.

Strengths are not people’s skills or talents or things we like about them. They are the resources they will use to overcome their illnesses. Strengths can be internal qualities like determination, hopefulness, self-awareness, self-responsibility, pride, a strong work ethic, family values, and spiritual faith. Strengths can be external resources like money, family, community, stable and safe housing, mentors and friends. Strengths can be discovered (or

Table 26.1

Person-Centered	Illness-Centered
The relationship is the foundation	The diagnosis is the foundation
Begin with welcoming—outreach and engagement	Begin with illness-assessment and diagnosis
Services are based on personal suffering and help needed	Services are based on diagnosis and treatment needed
Services work toward quality-of-life goals	Services work toward illness-reduction goals
Treatment and rehabilitation are goal-driven	Treatment is symptom-driven and rehabilitation is disability-driven
Personal recovery is central from beginning to end	Recovery from the illness sometimes results after the illness and then the disability are taken care of
Track personal progress toward recovery	Track illness progress toward symptom reduction and cure
Use techniques that promote personal growth and self-responsibility	Use techniques that promote illness control and reduction of risk of damage from the illness
Services end when persons can manage their own lives and attain meaningful roles	Services end when the illness is cured
The relationship may change and grow throughout and continue even after services end	The relationship only exists to treat the illness and must be carefully restricted to maintain professional boundaries

rediscovered) or newly developed. When someone has enough strength to overcome the next symptom increase, drug relapse, relationship breakup, job loss, family disappointment, or even tragic loss without falling apart, without becoming homeless or jailed or hospitalized, without losing everything they have worked so hard for, then they have resilience. Our goal is not to protect them from tragedies but to help them build enough resilience to handle the inevitable crises when they come.

As people grow, they move along a continuum from “unengaged” to “engaged but poorly self-coordinating” to “self-responsible.” People who are “unengaged” generally do not collaborate in their recovery. They might refuse all treatment, come in irregularly during crises, only want charity and entitlements but not treatment, or be brought into treatment repeatedly or involuntarily for being dangerous or disruptive. People who are “engaged, but poorly self-directed” might want to collaborate in their recovery, but have trouble coordinating the services they need. They may miss appointments, take medications poorly, abuse substances, or have poor skills or support. They need someone to help coordinate their services. People who are “self-responsible” can collaborate in their recovery and usually can coordinate it by increasing their resilience, self-sufficiency, and community integration.

These three levels of engagement are not exclusively related to consumer traits. System traits, primarily “ease of engagement” and “ease of coordination,” also affect the level of engagement. Programs that are more welcoming and accessible, with few barriers to treatment and that integrate multiple coordinated services at one site instead of scattered in several separate systems, are more likely to attract or retain consumers whose level of engagement had previously been marginal.

Table 26.2

Stage of Recovery	Caretaking Services	Growth Oriented Services
Extreme risk	External controls—locked environment, seclusion, restraints, 1:1 monitoring. Forced sedation. Reduce external interactions and stress.	Support to increase internal controls and self-responsible problem solving. Help to reduce internal sources of distress and loss of control. Trauma sensitive interactions.
Unengaged	Forced treatment Protection Benefits establishment Acute stabilization	Outreach and engagement Peer bridging Concrete quality-of-life goals Relationship building
Engaged, but poorly self-coordinating	Structure Making decisions for people Case management Chronic stabilization Board and care	Supportive services Skill building Personal service coordination Collaboration building Halfway house
Self-responsible	Benefits retention Maintenance therapy and medication Support groups	Community integration Self-help Peer support Wellness activities Growth promoting therapy

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Most consumers need both caretaking and growth-promoting services at different times in their lives in different combinations. However, the more a program emphasizes or relies upon caretaking services, the less likely it is to promote growth, personal strength, and resilience.

Readiness is a key concept in standard mental health services and is generally understood to mean “prepared and likely to succeed.” Traditional programs spend a lot of time assessing readiness and trying to create it so that people will be “ready” to leave the hospital, get a job, go to school, become their own payee, get off conservatorship or court-ordered treatment, get their own apartment, or effectively use or even get off medications. From a recovery perspective, “ready” means “motivated and excited,” and the focus is on exposure and building motivation. “Prepared and likely to succeed” comes from learning by doing, sometimes with guidance, but often as a result of trial and error. The job of staff is not to prepare ahead of time, but to actively support while the client learns by doing. Instead of trying to prevent or avoid suffering, the recovery goal should be to help consumers learn as they go, building strengths and resiliency for when they will be on their own.

3. Recovery-based services are “client-driven” instead of “professional-driven.”

Robert disappeared back under the bridge. The treatment team suspected that he'd either relapsed on speed or stopped taking his medication and was more psychotic. The peer outreach worker looked for him and found that neither of those things had happened. Robert was just scared and thought they were pushing him too fast. He agreed to return to “work for a day—house for a day.”

Six months later, he chose to move on to permanent work and an apartment. By the time the team celebrated his achievement with a housewarming party, he'd gained so much confidence dealing with the machine that he stopped his medications. The psychiatrist continued to see him and, although his old religious guilt returned, the machine remained very quiet. He worked on his shame and guilt without meds. He began volunteering by providing homeless outreach with his old peer counselor as a way to give back to others.

Robert felt proud of himself and the emotional closeness he had developed with the community of staff and program members, who reminded him of his lost family. The program helped him find his sister on the Internet and to visit her in a distant city. She welcomed her long-lost brother. Six months later, he decided to move to be with his sister, realizing that he was strong enough to make it without the treatment program.

Client-driven approaches were developed primarily to increase engagement and motivation in treatment. Traditional approaches incorporate a big differential in the relative power of the treatment transaction: a strong professional helping a weak person by doing something to or for them, which conveys a subtle, sometimes overt, message that the client/patient needs the professional in order to get better. A truly amazing array of client-driven approaches has been developed, primarily by non-clinicians, especially consumers in recovery. Here are some notable examples:

1. Personal Assistance in Community Existence (PACE)—A comprehensive approach to recovery built on self-directed, empowered usage of proven recovery beliefs, relationships, skills, identity, and community, especially useful for people who are not motivated by a medical approach for their “so-called mental illness.” (Ahern & Fisher, 1999)
2. Shared Decision Making—People are more likely to be motivated to work on plans they have had a part in creating and that reflect their contributions. (Davidson et al., 2010)
3. Motivational Interviewing—We can “meet people where they are” in the normal process of making difficult life changes (pre-contemplation, contemplation, planning, action, and sustaining), supporting them in their inevitable ambivalence with its “ups and backs.” This is likely to be more effective than always prescribing action and then getting frustrated, even coercive, and blaming them when they don’t follow through. (Miller & Rollnik, 2002)
4. Wellness Recovery Action Plans (WRAP)—People can create their own plans in a notebook for maintaining mental health, dealing with moderate stressors, and serious crises. WRAP can be done individually or in groups and can be facilitated by trained peer counselors. (Copeland, 2002a,b)
5. Advance Directives—Serious mental illness can lead to times of losing control and the ability to make competent decisions, even for people who are generally doing well in recovery. Just like people prepare for medical deteriorations by creating advance directives to make their choices known ahead of time and to appoint a surrogate, people can create advance directives for future psychiatric crises. Many states have legal supports for advance directives (Backlar, 1997; Fisher, 2000).

True collaboration requires understanding how other people view themselves and their lives, rather than just teaching them our point of view. It requires understanding their goals instead of ours, looking for shared goals that both parties can value and enthusiastically pursue. It requires clinicians to be compliant with consumers’ plans as much as expecting consumers to be compliant with professionals’ plans. It requires sharing power and actively empowering people. In particular, it requires mutual trust.

WHAT ARE “RECOVERY-BASED” SERVICES?

A typical set of services that promote engagement, self-responsibility, and community integration, while incorporating self-help activities that facilitate recovery, would include the following:

1. *Engagement and welcoming*—Focus on relationship- and trust-building services, not on requiring diagnosis or insight or medication; “meeting people where they’re at”; harm reduction; “housing first”; peer engagement; outreach; and charity.
2. *Person-centered planning and goal-driven services*—Develop a shared story of the person’s life instead of a history of illness, identify strengths to be used in recovery, assist in formulating goals to pursue collaboratively, identify potential barriers and develop

- shared plans to overcome barriers, develop goal-setting skills, and use a menu of services supplied by an integrated team and community.
3. *Sharing decision-making and building self-responsibility*—Develop collaborative relationships, describe service choices in understandable language and as it impacts the consumer's goals; "client-driven services," advance directives, assist clients in learning from consequences of decisions to learn to make new choices—learn from mistakes; define respective roles in achieving goals; increasing self-responsibility and self-reliance.
 4. *Rehabilitation-building skills and supports*—Do things with people instead of for them; use "teachable moments," *in vivo* skill building; assist with entitlements, supports, and opportunities; psychiatric rehabilitation and psychosocial rehabilitation; clubhouses and learning roles; peer support.
 5. *Recovery-based medication services*—Consider treatment optimization approaches that balance judicious use of medications with other treatment, rehab, and recovery interventions, with particular emphasis on patient/client/consumer preference. Align use of medications with the consumer's goals, instead of symptom control. Getting patients to take their medication to improve their symptoms needn't precede rebuilding lives. Medications can initially be for "short-term" effects until a "customer relationship" is built. Getting off medications happens when they're no longer needed to attain and maintain goals, not when symptoms are relieved. Medications enable self-help coping techniques, rather than competing with them. (Muesser et al., 2002)
 6. *Peer support and self help*—Cultivate opportunities for outreach and engagement, peer counseling, shared stories and humanity, peer advocacy, peer bridging, acceptance, "giving back," peer support groups, 12-Step groups, coping skills, self care, WRAP. (Georgia Mental health Consumer Network, 2003; Jonikas & Cook, 2004)
 7. *Adapting and integrating therapy and healing*—Provide therapeutic relationships without excessive structure or rules. Emphasize engagement, relationship building, "corrective emotional experiences." Create a healing environment—sanctuary, counterculture of acceptance, "therapeutic milieu," group therapy without walls, Carl Rogers' client centered approach that emphasizes providing empathy, authenticity, and caring to help people grow without needing a formal therapy structure.
 8. *Trauma-informed care*—Increase trauma awareness, empathetic relationships, trauma healing and recovery, personal safety and boundaries. Avoid retraumatization cycles and traumatization by staff, including reducing coercion, seclusion, and restraints.
 9. *Spirituality and alternative approaches*—For some persons, healing and recovery requires attention to their spiritual life. Faith and communing with others who share similar spiritual beliefs, without proselytizing or requiring participation in formal religious activities, can be a very powerful and supportive adjunct to feeling whole; inclusion of spiritual strengthening practices and healing.
 10. *Community integration and quality of life support services*—Identify needs and gaps in social supports, and provide benefits assistance, re-documentation, "supported services"—housing, education, employment, medical care, community development; finding "welcoming hearts" in the community; finding a niche; meaningful roles; community inclusion; rights and responsibilities; avoiding "failures of community integration"—hospitalization, homelessness, imprisonment.
 11. *Graduation and self-reliance*—Build strengths and resilience, protective factors, gifts from their suffering, overcoming fear of losing benefits and illness roles, replacing

professional supports with self-help and personal supports, developing community treatment resources, “coming out” to fight stigma and discrimination.

RECOVERY CHANGES EVERYTHING: RELATIONSHIPS, TEAMS, CULTURE, AND SYSTEM

To implement recovery-based services, there must be substantial transformation of treatment relationships. These changes are often threatening to staff who feel effective and safe within the bounds of traditional professional standards and ethics. Items like sharing bathrooms, giving choices to psychotic people, treating people without relying on medications, taking people in staff cars, eating lunch together, and encouraging relevant and ethical staff self-disclosure are lightning rods for staff resistance to recovery.

Recovery-oriented programs usually provide volunteer and staff positions for peers and family advocates. Persons with lived experiences of mental illness can provide specialized peer-based services, such as positions that involve outreach, peer-to-peer engagement, case management, life-rebuilding skills, and community development, and they can be hired in any position that they are qualified to do. The inclusion of such persons in the staff of a program can be disruptive to the traditional professional staff, who may worry or complain about risks associated with boundaries, ethics, or safety.

Recovery is not an “anything goes” model. One must be attentive to safety and ethics. Traditional ethics and safety rules evolved in a very risky and dangerous treatment arena: the isolated, secretive, individual private practice settings. It may be surprising and paradoxical, but activities that may not be safe, ethical, or appropriate within a private practice context can be provided and may be preferred in the context of a cohesive recovery-based team and program culture. Clinical rules regarding safety and ethics, and their rationale, must be reexamined and aligned with the goals of treatment and recovery: lowering boundaries and barriers, sharing power and responsibility, and engaging the community. Patricia Deegan has provided detailed guidance for the creation of new rules for new teams (Deegan, 2003). The Los Angeles County Department of Mental Health created a set of bureaucratic “Parameters for Service Relationships in a Recovery-Based Mental Health System” reconciling recovery values with existing policies and parameters (2006).

Team-based care is becoming the norm throughout all areas of health care. The relatively recent emphasis on patient-centered primary care homes and the integration of mental health and primary care are obvious examples of this rapidly growing trend. A recent report has identified the key core competencies for persons involved in collaborative care (Interprofessional Education Collaborative Expert Panel, 2011). In addition to the specific competencies associated with the person’s specific clinical discipline, this report specifies collaborative care abilities in four domains: values/ethics for interprofessional practice, roles/responsibilities, interprofessional communication, and teams and teamwork. Although most community-based mental health programs have provided some form of team-based care for decades, many have failed to truly develop teams to meet the aims of a quality health system; that is, to be patient-centered, effective, efficient, equitable, timely, and safe. These collaborative care competencies are relevant and underscore the shortcomings of traditional practices, whether individual or team-based.

Recovery programs need to be team-based and to cultivate these competencies because:

- We need to integrate a range of quality-of-life services beyond any one person's competence.
- People at different stages of recovery require different staff skills—engagement, building skills and support, moving on.
- None of us is Mother Theresa, but between us we can create “one Mother Theresa”: a broad “counterculture of acceptance” welcoming and engaging everyone in need.
- To safely and ethically lower boundaries and adopt multiple roles, we need to support and keep each other honest.
- To maintain staff morale and avoid our own trauma and burnout, we need to stick together and take care of each other.

Recovery-based programs are more readily differentiated from traditional programs by the values embedded in their culture than by the services they provide. Mental Health America of Los Angeles has created a recovery-culture progress report that rates programs from the perspective of consumers, families, line staff, and supervisors/administrators on seven key dimensions: Welcoming and accessibility, growth orientation, consumer inclusion, emotional healing relationships and environments, quality-of-life focus, community integration, and staff recovery and morale (Ragins, 2010). That final dimension is crucial and often overlooked: Staff should be treated in a recovery-based way, if only to increase their ability to treat their clients the same way. In many programs, staff morale is too low to allow a recovery-based culture. On the other hand, when a recovery-based culture is promoted, staff burnout diminishes and morale improves.

Recovery-based programs need to align all of their processes with recovery-based values and principles. Boston University's Center for Psychiatric Rehabilitation states that “A ROMHP [*recovery-oriented mental health program*] is characterized by program structures such as mission, policies, procedures, record keeping and quality assurance that are consistent with fundamental recovery values. Similarly, staffing concerns such as selection, training and supervision are guided by the fundamental values of recovery.” The BU document identifies four fundamental values: person orientation, person involvement, self-determination/choice, and growth potential (32). As the recovery movement matures, additional refinements are emerging, such as recovery-based supervision and mentoring, recovery-based administration, recovery-based funding, and recovery-based accountability.

IMPLEMENTING RECOVERY-BASED TRANSFORMATION

It is easier to create a new recovery-based program with selected staff than to transform an existing program. Resistance to change is common (Farkas et al., 2005). Keys to transformation include: Sustained coordinated leadership, creating “learning cultures” in the programs, improving connections between programs and administration, including and hiring consumers, and moving from a predominantly crisis-response mode to a proactive, team-based, planned mode.

The American Association of Community Psychiatrists created a policy document that is intended to facilitate the transformation to recovery-oriented services and to provide direction to organizations or systems that are engaged in this process. They should be useful to systems that have already made significant progress in creating services that promote recovery by providing a systematic way of thinking about quality improvement and management for these services.

The guidelines are organized divided into three domains of service systems: administration, treatment and supports. Each domain is composed of several elements and recovery-enhancing characteristics for each of these elements are described. Some suggestions for measurement of achievement/progress in each of these areas are included. (2003)

The revolution is still in progress:

Successful revolutions are rare in social systems and not all revolutions succeed, even if they should. True revolutions often take a generation or more to fully unfold and actualize. Progress can be tracked through stages of development; moving from innovators and early adaptors to growing acceptance to broad-based implementation.

Looking back at the history of the recovery movement thus far, there is clear evidence of progress.

1980s: Recovery Is Possible

- Longitudinal studies of recovery
- Individual stories of recovery
- Recovery doesn't have to mean cure—Recovery can occur with chronic illnesses
- Recovery is something the person does, not the illness—recovery is “person-centered”

1990s: Recovery Services Are Better

- Quality-of-life outcomes from model programs
- Inclusion of challenging populations who were dropping out, frustrating, and without recovery services, who “needed” coercion
- Improved staff morale and satisfaction
- Enhanced employment outcomes

2000s: Recovery Is Coming

- Widespread recovery transformation proclamations—President's New Freedom Commission, Veteran's Administration, California's Mental Health Services Act, SAMSHA's transformation states, other state initiatives
- Widespread persistent transformation efforts. “It's not just a fashion—you can't wait this out”

2010s: Recovery Is Practical

- Widespread development of recovery-based practices, programs, tools, and systems of care
- Recovery requires an integrated team—including psychiatrists and consumer staff
- Recovery is reasonably cost-effective compared with standard services—and probably even compared to neglect and cost-shifting
- Moving from recovery as an add-on for “outliers” to the core of the entire system

FUTURE CHALLENGES

In this chapter, we have:

- Outlined the roots of the recovery movement in mental health,
- Compared recovery to the prior two dominant models of care, the medical and rehabilitation models, and

- Described what recovery services are and how to implement them.

As recovery-based programs continue to emerge, develop, grow, and learn from their own and others' experiences, it is essential that the providers and consumers who endorse these approaches continue to improve the quality of the programs they create. We must also keep the "tipping point" process active by spreading the news that this is the effective and preferred way to meet the needs of the populations we serve, especially persons with severe and persistent mental illnesses and addiction disorders.

In order to sustain this revolution, we must apply recovery to the administration of programs; for example, through recovery-oriented leadership, mentoring, supervision, and accountability. Programs must manage their workload and avoid excessive caseloads, by creating efficient methods for allowing clients to flow through and graduate from programs. We must expand the effort to create and provide "strengths-based" services to build resilience and a sense of community into all of our lives, whether we are providers, recipients of services, or both. As the health system changes to one that is more primary care-based, we need to make sure that recovery principles and practices are a central part of the overall integration of mental health and addiction services with primary care. History suggests this will not be easy, because health integration means "medical model." But whether our revolution succeeds is up to all of us. There will be much more work yet to be done, some of which will involve educating our colleagues.

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