DRAFT 03/01/06

Building Resilience, Facilitating Recovery, Fulfilling the Promise

A Resource for Local Mental Health Services Act Planning

Produced by the
California Association of Social Rehabilitation Agencies
under contract with the
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Draft for Review

DRAFT 03/01/06

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Table of Contents

DRAFT 03/1/06

INTRODUCTION

The passage of the Mental Health Services Act[1] provides a once-in-a-lifetime opportunity to access a significant amount of resources to accomplish several tasks that have been unfulfilled by the California mental health system. The first is to assert that the mission of public mental health services in California is to improve the lives of people diagnosed with mental illness, not just treat the symptoms of mental illness. The second is to articulate a set of agreed upon principles and services to address quality of life and are based upon rehabilitation and recovery oriented practices.

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

Our challenge is to make the vision of recovery real. To help us achieve this vision, this toolkit has been created with three purposes:

The first is to recognize that we do, in fact, have some tools (and a toolbox)! Twenty years ago 'recovery' was a rarely heard concept or, at best, considered an expression of wishful thinking. Today, we not only know that "recovery" is a fact, we know much more about what consumers do and do not find helpful.

This leads us to our second purpose. Undoubtedly, there will be those who believe that a diagnosis of major mental illness carries a future of life-long disability and inability. Therefore, tools are needed to refute this ingrained mistaken belief.

The third purpose is to provide tools to reinforce the belief that mental health recovery is possible and to assure that this belief pervades all levels of the mental health delivery system.

This toolkit is for consumers, family members, providers, advocates and community members who are committed to developing local systems of services that are based upon the promise of growth and recovery. It is our hope that this toolkit will be a springboard in your system remodeling job. This is not meant to be a definitive list of tools and activities nor the only way to

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

approach a recovery-oriented system. It is our hope that you will invent tools of your own based upon the principles of recovery; it is our intention to provide the basics for you to get the job started.

In the following pages we will review the concept of recovery; review what we mean by that term, describe the history of the recovery movement in California, and define the guiding principles of a recovery-oriented mental health system. We then present a comprehensive look at Best Practices focusing on system design, programs and services, workforce development, and community.

What Is Recovery?

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

Pat Deegan[2] (1995) eloquently describes recovery in the following terms:

> "The concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings. Like a pebble tossed into the center of a still pool, this simple fact radiates in ever-larger ripples until every corner of academic and applied mental health science and clinical practice are effected.
>
> Those of us who have been diagnosed are not objects to be acted upon, we are fully human subjects who can act and in acting, change our situation. We are human beings and we can speak for ourselves. We have a voice and we can learn to use it. We have a right to be heard and listened to. We can become self-determining. We can take a stand toward what is distressing us and need not be passive victims of an illness. We can become experts in our own journey of recovery.
>
> The goal of recovery is not to get mainstreamed. We don't want to be mainstreamed. We say let the mainstream become a wide stream that has room for all of us and leaves no one stranded on the fringes."
>
> Pat Deegan, Ph.D., 1995

Bill Anthony[3] (1993) takes another approach to recovery:

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

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

DRAFT 03/1/06

"Recovery is a process and experience that we all share.

People face the challenge of recovery when they experience the crises of life, such as the death of a loved one, divorce, physical disabilities, and serious mental illness.

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

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

Bill Anthony, 1993

Recovery

is <u>not</u> about…	**<u>is</u> about…**
having no symptoms	managing symptoms
work	meaningful activity
level of functioning	quality of life
maintenance and stabilization	self-sufficiency and independence
medication compliance	lowest dosage necessary
coercion and compliance	collaboration and having a voice
motivation	rekindling hope

Taken from the Opening Plenary by Amy Long at the CASRA Fall Conference, Culver City, 11-5-99.

DRAFT 03/1/06

Why "Recovery?"

Despite 30 years of evidence to the contrary, many mental health service systems continue to be based upon the mistaken belief that persons with severe mental illnesses cannot recover. This belief contends that the long-term prognosis is one of continuing deterioration or, at best, holding steady at a level of major disability and impaired functioning.

Based upon the convergence of three major factors (first person accounts of recovery, empirical research, and the emergence of social rehabilitation), we now know that recovery from mental illness is not merely rhetoric nor wishful thinking, yet instead a fact.

Writings of Consumers

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

Empirical Work of Harding and Associates

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

Social Rehabilitation Approach

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

The last thirty years have also seen the emergence of the philosophy and principles of social rehabilitation (also referred to as psychosocial rehabilitation) and the recognition of its importance to inform systems and services. One example is the work of Harding (Desisto, et al., 1995)[5] that involved comparing the long-term outcomes of people with psychiatric disabilities served in two different systems in two separate states. This study concluded that the differences in recovery outcome were due to the presence, or lack thereof, of a rehabilitation orientation.

The growing literature on the advantage of providing psychosocial rehabilitation services to people in recovery from mental illness is summarized in the recent Surgeon General's report.[6] It urged the mental health field to "move forward as quickly and efficiently as possible to achieve a more

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

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

[6] Mental Health: A Report of the Surgeon General (1999), p. 287.

competent and expanded workforce necessary to ensure the full opportunity for recovery, resiliency, and wellness for all Americans with mental illnesses."[7]
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Resources

http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/ralphrecovweb.pdf
Ralph, Ruth O "A Synthesis of a Sample of Recovery Literature 2000 Prepared for the National Technical Assistance Center for State Mental Health Planning and the National Association of State Mental Program Directors."

http://www.patdeegan.com/
Discussion about recovery, video Inside/Outside.

http://www.bu.edu/cpr/about/profiles/wanthony.html for bio and a selection of articles by William Anthony

http://www.bu.edu/resilience
Institute for the Study of Human Resiliency

Deegan, Patricia E., "Recovery as a Journey of the Heart", in Psychiatric Rehabilitation Journal, 1996, Vol. 19 No.

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

DRAFT 03/1/06

Concepts of Recovery

The goal of mental health recovery is full integration into all aspects of community life. Recovery is a process, and many have found the following four stages described by Mark Ragins, M.D. a useful conceptual framework.

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

Empowerment
To move ahead, individuals need a sense of their capabilities. Hope needs to be focused on what they can do for themselves. To be empowered, they need access to information and the opportunity to make their own choices.

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

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

Philosophical Principles and Values

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

Self-determination

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

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

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

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

Community Integration
Mental health recovery does not happen in isolation but includes full integration and participation in all aspects of community life. Living, working, education, finance, spiritual, and social goals should be addressed. These areas often form the core of an individual's participation in community life. Campaigns to combat stigma and discrimination must be fought to support consumers' full inclusion in the community.

Resources

Anthony, William A., "Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s", 1993

Anthony, William A., "A Recovery-Oriented Service System: Setting Some System Level Standards" in Psychiatric Rehabilitation Journal, Fall 2000, Vol. 24, No. 2

Ragins, Mark, MD, "The Road to Recovery", 1998

DRAFT 03/1/06

Wellness and Recovery Initiatives in California

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

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

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

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

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

The Integrated Services Agencies (1988) initiative combined the need for comprehensive and integrated services designed to address the quality of life of persons diagnosed with mental illness.

Implementation of the Rehabilitation option under Medicaid and the realignment of funding for public mental both furthered the movement to a rehabilitation and recovery-oriented system. The Rehabilitation option provided a fiscal incentive (in the form of federal financial participation) to maintain rehabilitation services in tight financial times. And Realignment removed the fiscal benefit to Counties when placing consumers in state hospitals and skilled

nursing facilities by transferring the responsibility to pay for the cost of institutionalizing clients.

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

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

FY 1999-2000

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

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

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

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

- *California Wellness/Recovery Taskforce is formed.*

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

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

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

- *CMHDA Adult System of Care Partnership Conference.*

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

FY 2001-2002

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

  With the sponsorship of CIMH, the California Wellness and Recovery Taskforce designed these events to introduce consumers, family members and providers to the promise and reality of recovery from major mental illness. The content included a summary of the research findings debunking the myths about mental illness and introduced a conceptual framework for describing the components of recovery: hope, choice/self-determination, personal responsibility and finding a meaningful role in life.[8]

- *Pathways to Wellness video*

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

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

  The survey was designed to identify steps that are supportive of a recovery initiative. Among the items noted:

  - A Wellness & Recovery taskforce that is composed of consumers, family members and providers working in collaboration.
  - Recovery, quality of life, or other principles expressed in mission statements.
  - Opportunities exist for consumer employment in mental health positions at all levels.

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

- Peer counseling training program
- A wellness/recovery center or other consumer-run, drop-in service.
- Systematic staff and intern training on recovery-oriented principles and practices and supervisory practices that support rehabilitation/recovery-oriented practices.
- Persons with psychiatric disabilities in leadership roles within department management.

FY 2003-2004

- *CA Wellness & Recovery Taskforce continues to meet and serve as clearinghouse and "culture bearer" for the vision of a recovery-oriented mental health system.*

- *Bay Area Counties continue regional collaboration.*

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

FY 2005

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

Thirty-five years ago, we didn't know how to help people cope with the frequently disabling effects of serious mental illness. Now we do.

Thirty-five years ago, we did not know that the majority of children, adults, and older adults experiencing serious mental health problems, could recover. Now we do.

With extraordinary leadership and support, Proposition 63 went on the November 2004 ballot and passed.

The Mental Health Services Act acknowledged the following:

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

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

Using MHSA Funds Strategically

Whether you seek system transformation or metamorphosis, neither can be accomplished without the redirection of local resources from hospital and other institutional care settings.

The most important potential for MHSA funds lies in the ability to use this new money to develop resources - at the acute and institutional end of the service spectrum - that allow the redirection of local resources disproportionately spent in high cost hospital-based treatment settings or Institutes for Mental Disease (IMDs).

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

In other words, MHSA funds must be used strategically to leverage local dollars and State resources currently being spent in high cost settings or in non-Medi-Cal reimbursable institutions (IMDs and free-standing psychiatric facilities) by developing community-based residential treatment alternatives to these institutions that will allow the system to expand rehabilitation and recovery options at the community level. This approach can turn each dollar of MHSA funding into two or three dollars of available local resources.

DRAFT 03/1/06

FOCUS ON PRACTITIONERS

People don't care how much you know, until they KNOW how much you care.

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

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

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

12 Aspects of Staff Transformation[9]

By Mark Ragins, MD

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

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[9] This excerpt is from Mark Ragin's article *Proposition 63 Begins: Implementation Toolkit. The complete text can be found at: http://www.mhala.org/Proposition63Begins.pdf#search='12%20aspects%20of%20staff%20transformation'*

proactively guided process of staff transformation to succeed. This paper describes 12 aspects of staff transformation.

1. Looking Inward and Rebuilding the Passion: Recovery work requires staff to use all of themselves in passionate ways to help people. It cannot be done effectively in a detached, routinized way. Recovery staff tends to be happier, more full of life, and more actively engaged. To achieve this, staff need to look inwards to remember why our hearts brought us into this field in the first place. For many staff, our hearts have been buried under bureaucracy, paperwork, under-funding, frustrations, and burn out. Staff must be nurtured, encouraged to play and explore, to bring our lives into our work, and cherished for our individual gifts and hearts. Staff with hope, empowerment, responsibility, and meaning can help people with mental illnesses build hope, empowerment, responsibility, and meaning. Administrative leadership must effectively promote their staff before further transformation can occur.

2. Building Inspiration and Belief in Recovery: Staff spends the vast majority of time and emotions on people who are doing poorly or in crisis. We neglect the stories of our own successes and our roles in supporting these successes. Staff needs to be inspired by hearing people tell their stories of recovery, especially the stories of people we have worked with and also known in darker times. We also need to be familiarized with the extensive research documenting recovery and the concept of the "clinicians' illusion" that gets in the way of us believing in this research. Ongoing experiences of people achieving things we "know are impossible" are crucial.

3. Changing from Treating Illnesses to Helping People with Illnesses Have Better Lives: Recovery staff treat "people like people" not like cases of different illnesses. The pervasive culture of medicalization is reinforced by the infrastructure. Goal setting needs to reflect quality-of-life, not just symptom reduction. Data on quality-of-life outcomes need to be collected. Treatment must be life-based, not diagnosis-based. Assessments must describe a whole life, not an illness with a psychosocial assessment on a back page. Progress notes need to reflect life goals, not just clinical goals. Team staff meetings need to discuss practical problems of life.

4. Moving from Care-taking to Empowering, Sharing Power and Control: Staff has generally adopted a care-taking role towards people with a mental illness. We act protectively, make decisions for them because of their impairments, even force them to do what we think is best for them at times. Recovery practice rejects those roles, although many staff and mentally ill people are comfortable with them. Analogously to how

parents must stop being caretakers for their children to become successful adults, staff must stop being care-takers for people we work with in order for them to recover. There are enormous issues around fear of risk taking, feelings of responsibility for the people we work with, and liability concerns that become involved as staff try to become more empowering. There may also be personal issues around power and control. Most staff feel most efficient and effective when we are in control and people are doing what we want them to. Especially when facing repeated failures, or crises, frustration is likely to grow. We are likely to reject collaboration and want to take more power and control.

5. Gaining Comfort with Mentally Ill Co-Staff and Multiple Roles: Recovery requires breaking down the "us vs. them" walls. People with mental illnesses must be included as collaborators, co-workers, and even trainers. Working alongside mentally ill people as peers (not as segregated, second-rate staff) is probably the single most powerful stigma reducing and transforming experience for staff. For people with mental illness to recover and attain meaningful roles beyond their illness roles, staff need to take on roles beyond our illness treatment roles. Programs can promote this transformation by creating activities like talent shows, cook-outs, neighborhood clean-ups, art shows, etc., where staff and mentally ill people interact in different roles.

6. Valuing the Subjective Experience: Staff have been taught to observe, collect and record objective information about people to make reliable diagnoses and rational treatment plans. Recovery plans are collaborative. To achieve this collaborative partnership, staff must appreciate not just what's wrong with a person, but how that person understands and experiences what's happening. Knowing what it would be like to be that person, what they're frightened of, what motivates them, what their hopes and dreams are, are all part of a subjective assessment. Charted assessments, "case conferences" (shouldn't these be "people conferences"?), team meetings, and supervision all should value subjective understandings.

7. Creating Therapeutic Relationships: Recovery work emphasizes therapeutic work more than symptom relief. Our present system relies on illness diagnosis, treatment planning, treatment prescription, and treatment compliance. Staff can be interchangeable, professionally distant, even strangers, so long as the diagnosis, plan and compliance is preserved. Recovery work relies on the same foundation as psychotherapy: (1) an ongoing, trusting, collaborative, working relationship, (2) a shared, explanatory story of how the person got to this point, and (3) a shared plan of how to achieve the person's goals

together. Staff need to gain—or regain—these skills. Program designs must prioritize relationships so staff can create relationships.

8. Lowering Emotional Walls and Becoming a Guiding Partner: People repeatedly tell us that we are the most helpful when we are personally involved, genuinely caring, and "real". Psychotherapeutic and medical practice traditions, ethical guidelines, risk management rules, and personal reluctance come together against lowering emotional walls. Staff need a lot of discussion and administrative support to change in spite of these strong contrary forces. To best support a person on their path of recovery, staff need to act not as detached experts giving them maps and directions, but to actually becoming involved, walking alongside them as guides, sharing the trip. Staff's emotional and physical fears of the people we work with need also need to be dealt with in order to lower the walls.

9. Understanding the Process of Recovery: Staff are familiar with monitoring progress as a medical process. We follow how well illnesses are diagnosed, treated, symptoms relieved, and function regained. We alter our interventions and plans based on our assessment of this process. Recovery work monitors a very different process - the process of getting well. Analogously to the grief process hospice works with, the recovery process can be described by a series of 4 stages: (1) hope – believing something better is possible, (2) empowerment - believing in ourselves, (3) self-responsibility - taking actions to recover, and (4) attaining meaningful roles apart from the illness. Where hospice staff help people die with dignity, recovery staff help people live with dignity. Staff grow in their understanding of the recovery process and their skills in promoting recovery.

10. Becoming Involved in the Community: Recovery tries to help people attain meaningful roles in life. These roles will require them to be reintegrated into the community, to be welcomed and to be valued, to find their niches. Recovery cannot be achieved while people are segregated from their communities or protected in asylums. To support this, staff must work in the community. We can't be segregated from our communities or act solely as protectors in asylums. We need to be welcomed and valued and to find our niches. This is a substantial change for most staff and may trigger personal insecurities. Community development and anti-stigma work are important new programmatic and staff responsibilities.

11. Reaching Out to the Rejected: Recovery is being promoted, not just as a way of helping people who are doing well do even better, but also as a way of engaging with and helping people who do not fit well with the

present system. Recovery programs have proven success with people with dual diagnoses, homeless people, jail diversion people, “non-compliant” people, people with severe socio-economic problems, and people lacking “insight”. Each of these people has different serious obstacles to engagement and treatment, and staff often have serious prejudices against them. A “counter-culture of acceptance” needs to be created to work with them. This often requires both an attitudinal change in staff and training in specialized skill sets. The system transformation will not be considered a success if we continue to reject these people in need.

12. Living Recovery Values: “Do as I say, not as I do” is never a good practice. When the walls and barriers are reduced and emotional relationships enhanced in a good recovery program, it’s even harder to hide. Staff must live the values of recovery and be actively growing ourselves if we expect to be effective recovery workers. In recovery, the same rules and values apply to all of us.

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

Resources

The Village ISA - http://www.village-isa.org/

DRAFT 03/1/06

Hope Instilling Strategies

Numerous studies have demonstrated that people can and do recover from major mental illness though it is not possible to predict when recovery will occur. This fact has profound implications for the role and responsibility of service providers.

Hope, the belief that recovery is possible, is the key.

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

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

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

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

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

Table 1: Types of Hope-Inspiring Strategies

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

appropriately.	and purpose in life. Supporting the person's spiritual beliefs.	

Resources

Russinova, Zlatka, "Providers' Hope-Inspiring Competence as a Factor Optimizing Psychiatric Rehabilitation" in Journal of Rehabilitation, October/November/December 1999.

DRAFT 03/1/06

Competence in Psychosocial Rehabilitation Practice

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

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

In 2002, the California Association of Social Rehabilitation Agencies (CASRA) completed a 4-year project to delineate the core competencies of psychosocial rehabilitation practice and to develop a curriculum that could be used in either academic or employment settings. The project included a definition of a Psychosocial Rehabilitation Practitioner and recommended a Medi-Cal regulatory change to include the certified Psychiatric Rehabilitation Practitioner as a qualified mental health professional under the category of "Mental Health Rehabilitation Specialist." [10]

Definition of Psychosocial Rehabilitation Practitioner

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

Psychosocial Rehabilitation Practitioners are competent to:

- respond to the culture/ethnicity of person they serve
- partner with the consumer to formulate a strengths assessment and assessment across life domains, i.e., family, friends, intimacy, housing, work, education, money, health, leisure, creativity and spirituality
- partner with person with psychiatric disabilities to identify and address barriers that interfere with [or block] goal achievement
- assess need for and provides access to other professional health, human, social, legal and financial services
- partner with person to explore and evaluate choices and identify goals and options for services

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

- participate as team members within a service delivery team and with the person and the person's support system
- partner with the person's chosen service providers (including physicians), personal support system (including family members) and community resources
- provide service coordination directly or participate with person's service coordinator
- provide supportive counseling
- provide skill training in accordance with a person's goals
- assist person to garner support and access community resources beyond the formal helping systems
- assist person to access self-help and alternative support and services
- partner with person to develop resources to meet their needs
- advocate for person to secure resources, supports and benefits
- assist person in accessing and utilizing non-mental health services and supports, thereby reducing dependency on the mental heath system
- provide outreach and engage with people who do not use but may benefit from services and support
- engage the community in supporting people with psychiatric disabilities
- advocate for equal treatment and services for people with psychiatric disabilities

Psychosocial Rehabilitation Practitioners do not:

- provide psychotherapy
- formulate diagnoses
- practice independently
- recommend, prescribe or administer medications

DRAFT 03/1/06

FOCUS ON PROGRAMS AND SERVICES

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

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

Supported Housing

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

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

Opportunities

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

It costs essentially the same amount of money to house someone in stable, supportive housing as it does to keep that person homeless and stuck in the revolving door of high-cost crisis care, emergency housing, and incarceration. In addition, studies indicate that supported housing residents have:

- Decreases of more than 50% in tenants' emergency room visits and hospital inpatient days; decreases in tenants' use of emergency detoxification services by more than 80%; and increases in the use of preventive health care services.

- Increases of 50% in earned income and 40% in the rate of participant employment when employment services are provided in supportive housing.

- A study of 900 homeless people with mental illness provided with supportive housing found 83.5% of participants remained housed a year later, and that participants experienced a decrease in symptoms of schizophrenia and depression.

Key ingredients in Supported Housing include:

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

Action Steps

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

Examples

Name:	**Paseo Glenn Apartments**
Location:	San Diego County
Owner:	The Association for Community Housing Solutions (TACHS)
Service Provider:	TACHS and AB2034 Program
Number of Units:	14
Population Served:	Homeless, adults with mental illness

Funding Sources:	Multifamily Housing Program, Supportive Housing Program, Affordable Housing Program (FHLB),[11] Home funding (LIIF and CSH loans to acquire)[12]
Name:	**Stony Point Commons**
Location:	Sonoma County
Owner:	Community Support Network (developed by Burbank Housing and Community Development Corporation of Santa Rosa)
Service Provider:	Community Support Network
Number of Units:	16
Population Served:	Homeless, adults with mental illness
Funding Sources:	Supportive Housing Program, Affordable Housing Program, Local Redevelopment Agency, (CSH loan to acquire)

[11] FHLB – Federal Home Loan Bank

[12] Liif - Low Income Investment Fund
CSH – Corporation for Supported Housing

DRAFT 03/1/06

Supported Education

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

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

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

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

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

Opportunities

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

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

Supported education programs and services follow the psychiatric rehabilitation model of choose-get-keep; assisting individuals to make choices as to desired paths for education and training, helping them to get into an appropriate

education or training program, and assisting them to keep their student status within that program until their goals are achieved.

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

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

Action steps

- **Assess educational opportunities** in the community including high school academies, adult education, certificate programs, community colleges, and private and public universities,.

- **Form a work group.** If no formal supported education program exists, form a work group of educators, mental health professionals,employers, consumers, and family members to develop a plan for providing supports for education.

- **Access training resources and consultation** which are available through the Mental Health/Department of Rehabilitation Co-op.

- **Provide training opportunities for staff.** This training would include recovery principles and the relationship to supported education, an overview of models (e.g. choose, get, keep) and a review of local resources.

- **Provide Suppored Education (S. Ed)** training and technical assistance to Disability Support Service (DSS) practitioners to better address the service needs of students with psychiatric disabilities.

Examples

Mental Health/Department of Rehabilitation Coops

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

Caminar (San Mateo county)

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

Resources

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

DRAFT 03/1/06

Supported Employment

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

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

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

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

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

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

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

Employers who have hired persons with serious mental illness in the past are generally very positive about their experiences.[13]

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[13] See the following:

Lehman, A. (1995). Vocational rehabilitation in schizophrenia. *Schizophrenia Bulletin.* 21:645-656.

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

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

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

Opportunities

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

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

There are distinct advantages to creating the role of "employment specialist" on a service team. In this model there is generally better collaboration between various service providers and vocational services, services are individualized and based on the consumers' needs and wants.

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

Action Steps

- **Create county-wide or area-wide task force.** This task force would review employment services, identify gaps, and make recommendations for additional program development.

- **Identify key persons in employment services** from mental health, rehabilitation, and mainstream workforce service providers (i.e. Employment Development Department, One Stop operators, Social Security) to meet periodically to coordinate services.

- **Provide training opportunities for staff.** The training would include recovery principles and the relationship to employment services, an overview of models of vocational services (e.g. choose, get, keep), and a review of local resources.

Examples

Mental Health/Department of Rehabilitation Coops

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

Ticket to Work

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

Exemplary Programs:

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

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

Crossroads Employment Services (Sacramento county)

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

Alliance for Community Care (Santa Clara county)

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

Employment Resources:

DRAFT 03/1/06

Disability Benefits 101 - World Institute on Disability
http://www.disabilitybenefits101.org/
Disability 101 provides comprehensive information about working with a disability in California. This site covers both state and federal issues that affect all workers with disabilities.

http://www.apse.org/
APSE: The Network on Employment – a membership group that provides advocacy and training in the integration of persons with disabilities into the workforce.

http://www.socialsecurity.gov/work/Ticket/ticket_info.html
Information about the "Ticket to Work Program" for people with disabilities wanting to return to work.

http://www.jan.wvu.edu/
Job Accommodation Network provides information to employers and consumers in developing effective Reasonable Accommodations.

http://www.pai-ca.org/PUBS/542901.pdf
The Ticket to Work and Self-Sufficiency Program – "The Ticket" on the Protection and Advocacy Incorporated website provides basic information about this work incentive program.

http://www.yourtickettowork.org
Website created by the National Alliance for Ticket to Work to provide information and resources related to the Ticket to Work Program.

http://www.casra.org/advocacy

DRAFT 03/1/06

Integrated dual diagnosis treatment

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

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

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

Solution

Integrated, Dual Diagnosis Treatment -- SAMHSA toolkit or

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

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

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

- Dual diagnosis is an expectation, not an exception.

- Persons with co-occurring disorders are not all the same.

- Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting.

- Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client and in each service setting.

- When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual primary diagnosis-specific treatment is recommended.

- Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" in which interventions are not only diagnosis-specific, but specific to phase of recovery and stage of change.

- There is no single corrective intervention for persons with co-occurring disorders.

- Clinical outcomes for persons with co-occurring disorders must also be individualized, based on similar parameters for individualizing treatment interventions.

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

- Create a work group composed of persons from mental health and substance abuse including families and consumers to review the CCISC model for organizing services and make recommendations for implementation.

- Provide training for staff in Motivational Interviewing and harm reduction.

EXAMPLE

Community Research Foundation - San Diego, CA
Several programs are on track to meet the criteria of "Dual Diagnosis Capability" as defined by Ken Minkoff, MD and Christie Cline, MD, creators of the CCISC model. These programs:

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

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

Resources

http://www.kenminkoff.com/ccisc.html
Dr. Minkoff presents a description and principles of the Comprehensive, Continuous, and Integrated System of Care (CCISC) for dual diagnosis treatment.

http://www.comm.psych.pitt.edu/finds/dualdx.html
Principles for the Care and Treatment of Persons with Co-Occurring Psychiatric and Substance Disorders as endorsed by the American Association of Community Psychiatrists.

DRAFT 03/1/06

Peer (Consumer) Run Programs and Services

Drop-in Centers

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

Opportunities

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

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

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

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

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

A second type of drop-in center is the type which functions as an independent, consumer-run entity, but which may have some contractual relation with a

larger non-profit organization. Even this type of center communicates strongly the idea that individuals can and do recover, earn a living and contribute to society.

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

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

Action Steps

Assess Your Drop-In Center

- How can you increase the autonomy of your Drop-In Center?

- Do consumers make all decisions and have a sense of ownership of the Center

- Should the hours of operation be adjusted to meet the needs and schedules of both members and consumer staff?

- What Peer Run services are available?
    - Peer Counseling
    - Support Groups
    - Warm Lines
    - Buddy system
    - Meals
    - Emergency Food baskets
    - Vocational services
    - Pre-Vocational Training
    - Clothing
    - Tender Loving Care[14] – In-Home Support Services
    - Community Projects
    - Recreational Outings

[14] TLC is a program where consumers assist fellow consumers with household or other tasks.

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

Examples

Berkeley Drop-In Center – *Berkeley (Alameda County)*
The earliest consumer-run Drop-In Center in California and is part of the consumer-run Alameda Network of Mental Health Clients.

Mental Health Consumer Concerns – *Contra Costa County*
MHCC is the second oldest consumer-run organization in the nation. The agency provides patients' rights advocacy in Contra Costa, Napa and Solano Counties and operates 4 drop-In type community centers.

Interlink – *Santa Rosa (Sonoma County)*
Consumer-run drop-In Center located in Santa Rosa that operates with Goodwill as their fiduciary agent.

Oasis Center – *San Francisco*
Consumer-run Center that operates with The San Francisco Study Center as their fiduciary agent.

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

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

DRAFT 03/1/06

Pre-vocational Training

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

Opportunities

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

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

Action Steps

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

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

  Other topic areas may include:

  - Dual Recovery
  - Crisis Intervention
  - Financial Benefits and Work
  - ADA rights

- HIV
- Charting and record keeping
- Facilitating groups
- How to help Suicidal Persons
- Violence de-escalation
- Medications
- Patients' Rights
- How to make referrals
- Cultural competence
- History of the Self Help movement
- Interviewing skills
- Resume writing.

Locate reading materials and assignments to distribute to class.

- **Identify Trainers with Needed Expertise**

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

- **Identify site to have training**

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

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

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

- **Develop intake materials for students**

- **Meet with professionals to develop internship/work-study positions**

  - Develop internship job descriptions – how many hours a week, skills utilized, is client contact required?
  - Does the system have entry level mental health positions that may be filled by your trained consumers?
  - Will staff at the internship sites need training to welcome and support consumer interns?

- **Funding**
    - Are you able to offer stipends or hourly wages for internships?
    - Identify employment/stipend paperwork for interns
- **Agreements**
    - Develop a standard of conduct that interns sign before beginning their internship
    - Develop written agreements or Memoranda of Understanding (MOUs) between internship sites and the training program
- **Supports for interns**
    - Weekly support and supervision groups
    - individual support when difficulties arise on site
- **Evaluation**

Consider developing evaluation forms to solicit feedback from:

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

- **Graduation**

Celebrate! – A ceremony validates the students' accomplishments

Examples

SPIRIT[15] **Training program** is a joint project of Mental Health Consumer Concerns and the Office for Consumer Empowerment in Contra Costa County. SPIRIT training provides training, internship opportunities and peer support.

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

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

[15] SPIRIT - Mental Health **S**ervice **P**rovider **I**ndividualized **R**ecovery **I**ntensive **T**raining

Wellness Recovery Action Plans (WRAP)

Consumers often have difficulty with recurring issues and feelings that may interfere with obtaining and keeping employment, success in school, or simply enjoying life.

Opportunities

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

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

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

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

With the assistance and support of a WRAP support group, the person who experiences symptoms develops their personal WRAP. The person may choose to have health care professionals help them create their WRAP.[16]

Action Steps

- Identify a consumer group that will sponsor WRAP support groups

- Locate funding to purchase WRAP books and training materials and for consumer coordinator/trainers to attend WRAP training at the Copeland Center.

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

- Hire consumer coordinator/trainer to develop WRAP facilitator training for local consumer facilitators.

- From graduates, identify support group facilitators. It is suggested that groups be co-led so that the group can continue when one facilitator is unavailable.

- Identify locations, dates, and times for holding WRAP support groups

- Advertise support groups

- Support group facilitators keep contact information for members and may provide peer support outside of meetings to deal with feelings that arise from looking at and talking about symptoms. Facilitators also keep track of statistics for funding purposes.

- Consumer coordinator/trainer provides training and supervision to facilitators which would include a monthly facilitator support group.

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

Examples

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

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

DRAFT 03/1/06

Health Maintenance Services

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

Opportunities

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

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

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

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

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

- Develop an agreement with a nursing program to provide basic health services on site both by nurse practitioners and rotating nursing students.

Action Steps

- Develop affiliations with nursing programs and/or FQHCs.

- Provide training for staff in evaluating physical health and wellness needs and developing a health maintenance plan.

Examples

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

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

DRAFT 03/1/06

Community Residential Treatment Alternatives

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

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

Purpose of Residential Treatment Programs

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

- to provide treatment alternatives for those individuals who would otherwise be admitted to, or remain in, acute and long-term hospitals or other institutional settings, including jails, due to the severity and seriousness of their disabilities; and

- to utilize a range of residential settings to move the mental health system from an institutional dependency to a community-based services capacity.

Permanent, affordable housing with necessary support services and vocational opportunities should be the basic building blocks of a community mental health system.

For those individuals who require or request more structured settings, a range of residential treatment alternatives to various levels of institutional or custodial care should be developed in order to assure that a system of care utilizes institutional beds only when it is absolutely necessary.

DRAFT 03/1/06

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

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

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

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

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

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

DRAFT 03/1/06

Crisis Residential Treatment

Twenty-years ago, the prevailing mentality was that crisis treatment could only be accomplished in a hospital environment. We now know that crisis stabilization, including drug response, can best be provided in a community-based setting. Community-based, home-like crisis residential treatment settings are more effective and far less expensive than hospital settings for acute psychiatric care. Evidence shows that crisis residential treatment is clinically comparable to hospital treatment for many clients at one-third to one-half the cost of hospitalization.

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

There are five tasks that must be undertaken to ensure the success of crisis residential programs.

Task #1:
Determine the level- of-care of the crisis residential program

The first task in the development of the crisis residential treatment program is to decide what level-of-care the crisis residential program will provide. The decision regarding the level of intensity of the crisis residential program is critical to subsequent decisions regarding program design, and staffing.

Respite oriented programs usually have only one person on duty at a time. The programs are designed for individuals who require an immediate structured housing setting, but only because their current housing is untenable. In many communities, the psychiatric hospital is the only setting that is available for admissions 24 hours a day, 7 days a week. Therefore, individuals with a situational crisis are placed in the most expensive setting because of the lack of an alternative that is as logistically convenient.

Sub-acute crisis residential programs have a more specific intent to divert individuals who are not yet acute enough for hospitalization, but who demonstrate a deteriorating condition that could soon result in hospitalization. The program is usually staffed by two individuals at all times. The programs do

not admit individuals who just require emergency housing, but are designed to intervene in a developing crisis.

Acute crisis residential treatment, also called acute diversion, is intended to provide an alternative to the hospital for individuals who are presenting acute psychiatric symptoms and who would, if the highly staffed and structured alternative were not available, be hospitalized. These services attempt to replicate the response of an inpatient unit, but within the philosophy and practice of a social model, voluntary setting.

Existing crisis residential treatment programs have found, in two decades of providing acute services, that **there are no kinds of behavior that cannot be treated successfully at this level of care.** The programs have admitted and served individuals who are violent, suicidal, and in the midst of an acute psychiatric episode. The programs have served individuals who set fires, those who have come to the attention of the psychiatric emergency system by committing a crime and those whose actual identities and social/psychiatric histories are unknown.

Task #2:
Determine the crisis program role in a continuum of services

The decision regarding the level of clients that the program will serve guides the development of systemic relationships that will have the greatest impact on inpatient or emergency room utilization. The acute residential treatment program, therefore, must look to a simple guiding principle in determining such critical issues as referral sources and the program's role in the larger continuum of care. The crisis residential program should determine where the decision to admit to the hospital is made, and place itself in the "line of fire" of that decision.

Task #3:
Determine the degree of system commitment to diversion

One of the critical systemic considerations is the degree of commitment to diversion from hospitalization as a "way of doing business." The most successful crisis residential programs emerge from a broad-based strategy to find effective alternatives to hospitals, jails and other institutions.

Task #4:
Assess the capability of the other elements of the crisis response system and the larger system of care to implement a diversion policy

DRAFT 03/1/06

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

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

(Excerpts from *Crisis Residential Treatment Toolkit* 2004 written by Steve Fields, Progress Foundation)

DRAFT 03/1/06

Transitional Residential Treatment

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

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

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

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

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

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

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

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

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

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

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

Dual Diagnosis Adult Residential Treatment

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

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

Example

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

Bonita House's conceptual framework incorporates principles of psychosocial rehabilitation within an integrated treatment model. Treatment is individualized, and is designed to address each client’s mental illness and substance use. Many people come to the program from locked, involuntary settings such as psychiatric hospitals. As a result, they have lost control of, and

responsibility for, their lives over time. The treatment approach seeks to re-empower program residents and to enhance their sense of trust through the formation of strong client-provider relationships.

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

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

- psychiatric symptom and medication management
- recovery and abstinence from substance use
- decision-making and independent living skills training
- pre-vocational and vocational training
- HIV/STD education
- health and nutrition education
- advocacy
- housing

The maximum length of time that a client can stay is 12 months; most residents stay in the program for about 6 months. Clients who leave prior to completion of treatment, about 30%, do so because they have either violated resident house rules, are incarcerated, have developed a need during treatment that the program cannot meet (e.g., physical health care), or have left against staff advice. Clients who complete the program are typically discharged to a clean and sober living environment, or other housing within a "harm reduction" community. [17]

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

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[17] There is no generally accepted definition of "harm reduction". However, the International Harm Reduction Association (IHRA) recommends that the term should be understood to mean, "…policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and their communities."

DRAFT 03/1/06

Programs for Women with Children

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

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

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

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

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

Programs for older adults

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

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

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

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

DRAFT 03/1/06

FOCUS ON SYSTEMS

Now that the MHSA has provided us the opportunity to transform the mental health system, let us focus on the systemic best practices. The challenge is to create a system that incorporates the philosophy and values of social rehabilitation and recovery. This new ideal would:

- Spread understanding of and belief in recovery
- Incorporate quality of life program elements which will lead to the creation of integrated services
- Incorporate quality of life outcome data into program monitoring
- Hire consumers and family members widely within mental health programs in a variety of roles as part of increased consumer involvement overall
- Create recovery-oriented infrastructures
- Create recovery-oriented leadership and culture
- Change practice expectations to value recovery-oriented practices; train and retrain staff in these transformed practices
- Build community coalitions
- Reduce (if not eliminate) the use of hospitals and institutional settings
- Incorporate engagement strategies for people who are homeless, institutionalized, and those in transition from the children's system of care to the adult service system.
- Involve consumers and families in all aspects of system planning and management

While there are substantial ongoing efforts in these areas among many mental health programs, transformations of social systems are notoriously difficult to achieve. The following collection of ideas, models, and resources is presented as a guide for the challenging task ahead.

Characteristics of a Recovery-Oriented System

SYSTEM DIMENSION	SYSTEM STANDARD
Design	Mission includes a recovery vision as driving the system and challenges the presumption of life-long need for mental health services Mission implies recovery measures as an overall outcome for system (e.g., empowerment, role functioning)

	Core set of services are identified based on consumer's needs and choices Services are designed to facilitate each individual's integration into the community of their choice Services are designed to be integrated and address co-occurring disorders
Evaluation	Incorporate 'quality of life' outcome and cost data into program monitoring and accountability Consumer and family measures of satisfaction and dis-satisfaction are included in system evaluation
Leadership	Leadership constantly reinforces recovery vision and recovery system standards Leadership has created a structure (e.g., Wellness/ Recovery Taskforce) where consumers, family members and providers come together to develop strategies to implement wellness and recovery-oriented practices Leadership nurtures, encourages staff to play and explore, brings their lives into the work, and cherishes staff for their individual gifts and caring Leadership has created opportunities for direct consumer and family participation in management (e.g., Office of Consumer Empowerment, Office of Consumer Affairs, Consumer Liaison Advocate)
Management	Recovery-values are reflected in supervisory relationships Decision-making is decentralized giving staff real authority in programs (e.g., access to funds to meet consumer needs) Policies governing risk management encourage risk-taking and view failures as opportunities for learning except in those instances where harm is imminent Policies insure that the MIS system collects information on service process and outcomes

	Policies encourage service programs to be recovery-oriented (i. e., procedures are compatible with recovery values and consumer outcomes) Policies encourage the assignment of service staff to be based on competencies and preferences rather than education and credentials
Service Integration	Coordination of services is provided for each consumer who wants and needs it Policies encourage the development and implementation of collaborative strategies to achieve consumer outcomes that cross service systems Policies do not allow for discrimination against persons with co-occurring disorders
Comprehensiveness	Consumers' goals address functioning in living, learning, working, and/or social environments Consumers' goals address the development of support systems Consumers' goals address building on services and supports available within the broader community
Consumer and Family Involvement	Individuals with psychiatric disabilities and families are actively sought for employment at all levels in organization User-controlled, self-help services are available in all geographic areas Family educations programs and support groups are available for family members Consumers and families are integrally involved in system design and evaluation A leadership development program is available to support meaningful participation in governance and system decision-making processes Services have a clearly defined procedure for eliciting and responding to client and family suggestions and/or

	complaints
Cultural Relevance	Policies insure that assessments, planning, and services' interventions are provided in a culturally competent manner Policies insure that the knowledge, skills and attitudes of personnel enable them to provide effective care for the culturally- diverse populations that might wish to use the system Policies emphasize deriving services, programs and interventions from the community(ies) being served
Advocacy	Staff and leadership advocate for a holistic understanding of people served appreciating the interplay of the mind/body connection. Staff and leadership advocate for an understanding of the potential for growth and recovery of people served Staff and leadership advocate for the recognition of the civil rights of people served Staff and leadership advocate for the implementation of the Supreme Court's Olmstead decision Staff and leadership advocate for the use of tools that emphasize empowerment (e.g., the development and implementation of psychiatric advance directives)
Training	Policies insure that all levels of staff understand the principles of recovery-oriented systems and the psychosocial rehabilitation approach to services and practice Policies encourage selection and training methods designed to improve knowledge, attitudes, and skills necessary to provide rehabilitation and recovery-oriented services Supervision addresses the implementation of new knowledge into practice Policies insure that staff training includes training provided by consumers and family members

	Policies insure that all levels of staff are competent in integrated dual diagnosis treatment approaches
Funding	Funding priorities emphasize developing alternatives to hospital and institutional care to transform reliance on medical/institutionally based care to a community-based, rehabilitation capacity Funding priorities emphasize redirecting local dollars saved by minimizing use of hospitals and Institutes for Mental Disease into an array of necessary, but non-MediCal reimbursable, services (e.g., supported employment, supported education, client-run drop-in centers)
Access	Services are available at locations that allow for access to community resources and public transportation Services are provided in settings that are wheelchair accessible Access to services and social supports is not contingent on medication compliance Timely access to services is ongoing and consistent with the principle of early intervention and in order to fore-stall relapses Meetings of governance and other decision-making bodies are accessible (e.g., public transportation, cab vouchers, elevators)

DRAFT 03/1/06

Be Strategic

Whether you seek system transformation or metamorphosis, neither can be accomplished without the redirection of local resources from hospital and other institutional care settings.

The most important potential for MHSA funds lies in the ability to use this new money to develop alternatives - at the acute and institutional end of the service spectrum - that allow the redirection of local resources that are disproportionately spent in high cost hospital-based treatment settings and Institutes for Mental Disease (IMDs).

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

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

DRAFT 03/1/06

A Guide for Recovery-Oriented Leaders

By Mark Ragins, MD

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

1) **Hope**: Hope is clearly the first step in anyone's recovery and our culture must actively promote it.
    1) Stories and celebrations of hope should be spread by both staff and consumers.
    2) Hiring of people who are open about their mental illnesses fills the program with living examples of hope.
    3) Goal setting for both consumers and staff should focus on growth rather than stability or risk avoidance, building on strengths as well as overcoming obstacles.

2) **Authority:** The distribution of authority has widespread implications for promoting empowerment, self- responsibility, risk-taking, and learning from mistakes for both staff and consumers.
    1) Decentralized decision-making gives line staff real authority in the program. Giving staff money for them to be responsible for and choosing how to spend is a concrete, powerful step.
    2) The program should include a substantive consumer voice at every level of the program's decision-making process.
    3) "Consumer driven" needs to be an overt, highly discussed part of the culture to ensure that decisions flow, as much as possible, up from the needs of the people we're helping rather than down from administrative authorities.
    4) Planned risk-taking, not care-taking or reckless abandonment, needs to be actively encouraged for both consumers and staff if growth is going to occur.
    5) Boundaries between staff and consumers need to be as low as possible to decrease "us vs. them" stigma.
    6) Staff and consumers need to have multiple roles and multiple kinds of relationships with each other for consumers to move beyond illness roles in their recovery. Staff and consumers helping each

other without "that's not my job" or "that's your job" defensiveness is a concrete, powerful step.

7) Staff and consumers both should feel important, valued, even treasured by those who have "*positional* authority" over them. Everyone is an expert in some way, a "chief" of something, with "*personal* authority".

3) **Healing:** In a recovery program the focus is on healing and growth for the person rather than symptom relief for the illness.
    1) The first priorities are engagement, welcoming, and relationship building because the foundation of a good recovery process is a good relationship, not a good diagnosis.
    2) A "counterculture of acceptance" needs to be established within the program to create an emotionally safe place for these "unacceptable", rejected people to recover within.
    3) The usage of respectful language rather than prejudicial, clinical language needs to be so pervasive that people can read their own charts or overhear staff discussing them and feel accepted and understood.
    4) A healing environment is an emotionally rich environment filled with open displays of caring and connection.
    5) To be effective, staff must be in touch with why their hearts brought them into this work and be energized by practicing their gifts.

4) **Community Integration**: To achieve meaningful roles in life we cannot stay isolated away from the world.
    1) Both staff and consumers must be mobile and actually work together out in the community on "real life" issues.
    2) The program must demonstrate accountability to the community by collecting "socially responsible", quality-of-life outcomes like housing, jailing, employment, and finances.
    3) The program needs to focus on community coalition building and "giving back" to the community if it and the people it works with are going to be accepted.
    4) Staff and consumers need to be actively involved in the difficult work of fighting stigma if our world is going to become a better place for people with mental illnesses to live in.

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

DRAFT 03/1/06

Creating "Exits" from the Mental Health System

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

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

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

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

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

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

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

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

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

Solutions

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

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

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

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

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

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

Action Steps

Increase number of community physicians willing to provide medication: Create list of psychiatrists who accept MediCal and/or Medicare. Brainstorm ways to increase the number of psychiatrists who will accept Medi-cal and Medi-care. It is crucial to provide consultation services to primary care physicians who are prescribing psychiatric medications.

Provide training for providers: Provide training tools for staff that promote and demonstrate an empowerment approach including an emphasis on skill development and fostering natural supports.

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

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

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

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

Examples

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

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

DRAFT 03/1/06

Incorporating a Recovery Perspective into System of Care Development

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

Wellness and Recovery Task force

The Statewide Recovery Task Force recommends that the topic of how to incorporate wellness and recovery into adult systems of care be assigned to a subcommittee, work group or task force of the mental health department. The Wellness and Recovery planning effort would be engaged in the following tasks:

- Developing an implementation time frame.
- Assessing the readiness of the adult system of care to begin implementation.
- Identifying useful workshops for staff on Wellness and Recovery concepts, and implementation issues.
- Arranging for suitable workshops to take place.
- Working with administration to identify and advocate for the necessary systemic changes. Be sure to include the county Adult System of Care (ASOC) strategic planning process.
- Development of sub-committees to address cultural competence, client and family inclusion within the system of care, spirituality, and education of staff.
- Monitoring of the implementation plan throughout the system.
- Conduct focus groups with a variety of consumer cohorts (transition age youth, ethnic/cultural minorities, older adults) to gather

information about their perspective on the concepts and implementation issues of wellness and recovery approaches.

Getting Organized

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

Wellness Recovery Center

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

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

DRAFT 03/1/06

Consumers in the Mental Health Workforce

Over the last 10 years, mental health providers have increasingly recognized the value of including persons with psychiatric disabilities in the mental health workforce. Dr. Mark Ragins states: "No single experience is a stronger stigma reducer, "us versus them" barrier breaker, or humanizer than working alongside consumers and family members. No single experience is more likely to change the entire mental health culture." Hiring consumers reflects the most basic values of psychosocial rehabilitation: community integration, belief in recovery, self-sufficiency and contributes to the creation of a multicultural workforce.

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

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

Developing Jobs for Consumers

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

- A review of workforce needs to evaluate service needs and organizational gaps in both administration functions and direct service.
- A review of job descriptions; adding experience as a consumer of mental health services in job qualifications, creating educational equivalencies to include successful completions of a peer counseling certificate, requiring CPRP certification for specific positions, and removing stigmatizing language in job descriptions.
- Creating diverse teams by integrating peer positions across teams, creating flexible schedules and job sharing

- Developing career ladders by creating entry-level peer counseling positions with opportunities for advancement; creating a culture where all positions could potentially be held by consumers; providing agency support for continuing education; using performance reviews to identify areas for professional growth; and matching job qualifications to job duties on a system level.

Preparing the Work Environment

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

Concerns of Staff

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

Concerns of Consumer Employees

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

Creating a Consumer-staff Friendly Work Environment

Addressing the concerns of staff (and perhaps the concerns of the board of directors, unions, and civil service) and creating an organization with a true recovery vision will require an ongoing commitment from all levels of the organization. Issues to be addressed include:

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

- **Inclusion**
  Inclusion in both professional and social staff activities is important as consumer employees must be treated with the same regard and respect

as any employee. Consumer staff should be included in all trainings as well as having a specialized track to address their specific needs.

- **Supervision**
  The supervisor must be supportive, communicate clearly and directly and be able to define job duties clearly. Standard job expectations must be maintained. The supervisor must recognize and be able to provide additional support and training.

- **Support**
  Be prepared to discuss and provide reasonable accommodations, develop support groups for consumer employees and provide ongoing training.

Education and Training for Consumers in the Mental Health Workforce

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

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

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

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

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

The CPRP is a professional standard that is within the reach of consumer staff.

Psychiatric Advance Directives

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

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

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

Recent changes in legislation in many States give individuals the right to specify, in advance, choices about how they will be treated in the event that their circumstances renders them incapable of exercising choice. The mechanisms for indicating choice are forms of “advance directives.” Advance Directives (ADs) involve the creation of legal documents during a time when the "illness" is not severe enough to impair judgment. The documents can: 1) specify consumer choices for treatment parameters (referred to as “instruction directives”), and/or 2) designate a durable power of attorney for medical decisions – a proxy – who is legally authorized to make choices on behalf of a person who has impaired decisional capacity (referred to as a “proxy directive”). The enactment of AD statutes present an exciting opportunity to extend empowerment to individuals with serious mental illness in the previously sacrosanct domain of involuntary psychiatric treatment as persons who are involuntary committed may lack decisional capacity for medical treatment.

Initial reactions from members of the judiciary indicate that the presence of an advance directive for psychiatric care would be perceived as very helpful in enabling judges to meaningfully comply with unified substituted judgment

standards that require judges to choose what the client/patient would have chosen.

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

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

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

- Specific treatments that have and have not worked in the past
- Who is to be notified that involuntary commitment has occurred
- Who is to be allowed to visit the consumer in the hospital
- Consents to contact previous care providers
- Consumer preferences for particular pharmacological treatment regimens along with rationale for choice
- Consumer preferences regarding electroconvulsive therapy (ECT)
- Consumer preferences about how to handle "emergency forced treatment" (i.e., medication versus seclusion versus restraints)
- Consumers' instructions about what should be done about child care (temporary custody) for their children during the commitment
- Consumer preferences for "types of activity therapy"
- Consumer desires about which hospital and physician they would prefer
- Consumer preferences for community-based round-the-clock acute care alternatives to hospitalization
- Consumer preferences regarding lengths-of-stay in combination with preferences for type of residential arrangements at discharge (e.g., shorter hospitalization followed by discharge to a more intensive aftercare unit (if available), versus longer hospital length-of-stay in combination with a discharge back to the pre-crisis residence)

- Consumer preferences for typical and customary treatments (non-experimental) that have not been tried previously for this consumer's condition
- Consumer's willingness to be approached for consent to participate in informal/formal experimental studies while hospitalized
- Experiential anecdotes about what occurred during past hospitalizations that the consumer perceived as beneficial and what might have been the "trip wires" that set off negative reactions
- Preferences for aspects of medical care (i.e., life sustaining treatments "do not resuscitate orders, organ donation, etc.)

In summary, ADs present a wonderful opportunity to: 1) enable mental health consumers to influence involuntary psychiatric care, 2) provide important information to guide physicians in making difficult treatment decisions, 3) ease the burden of judges attempting to guess what a consumer would prefer, and 4) simultaneously reduce the length of commitment and costs associated with involuntary care. If we are adamant in supporting rights to treatment and informed choice as well as rights to refuse treatment, we must recognize the logical extension of those rights to include the right to use mechanisms to plan for treatment and informed choice at a future date when we may not be as able to coherently express our choices.

Persons diagnosed with mental illness have a right to an advance directive. It is time we mounted a national campaign to educate people about this right and why they should consider executing advanced directives for involuntary psychiatric interventions. Furthermore, we need to develop systems that can alert professionals, in times of crisis, that an advance directive exists and create ways for those documents to be accessible.

Resources

http://www.bazelon.org/issues/advancedirectives/faq.htm
Frequently Asked Questions about Psychiatric Advance Directives on the Bazelon Center fro Mental Health Law website. Forms that can be used to create Advance Directives are on the website.

http://www.power2u.org/selfhep/directives_work.html
Fisher, Daniel "Making Advance Directives Work for You" on the National Empowerment Center website

http://www.power2u.org/selfhep/directives.html
Williams, Xenia "Advance Directives Are What You Make Them" on the National Empowerment center website

Srebnik, D. et. al. (2005) The content and clinical utility of psychiatric advance directives. *Psychiatric Services.*

Outcomes

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

The AB 2034 programs'[18] have collected quality of life outcomes from their inception. Their ability to document effectiveness, especially in decreased homelessness, incarceration, hospitalization and increased employment, has been instrumental to the political support for the Mental Health Services Act (Proposition 63).

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

Although all types of outcomes are important, when limited resources force us to choose between different types of outcomes, emphasis should be placed on outcome types in the following descending order of priority: Quality of life, functioning, adverse impact, and clinical (symptomatology). (See McGlynn, 1996, for a more detailed discussion of the different types of outcomes.)

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

Objective Quality of Life (Real-time) Domains

- Housing
- Employment
- Educational
- Legal
- Income
- Conservatorship

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

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

- Payeeship
- Incarceration
- Hospitalization
- Criminal Victimization

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

Consumer Satisfaction

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

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

The *Consumer Report Card* developed under the auspices of the Mental Health Statistics Improvement Program (MHSIP) continues to represent the standard in the field.

The *Report Card* was developed in collaboration between consumers, the MHSIP community and the Center for Mental Health Services.

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

The MHSIP Report Card [19]

With the rapidly increasing interest in assessing the quality and cost of healthcare services, several mental health report cards have emerged. Among these, the MHSIP report card is unique in a number of ways.

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

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

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

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

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

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

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[19] The Mental Health Statistics Improvement Program can be found online at http://www.mhsip.org/. The website includes links to sample surveys

DRAFT 03/1/06

Partnership and Collaboration

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

Collaboration with local housing authorities

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

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

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

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

The Section 8 Moderate Rehabilitation Program (Mod Rehab or Section 811) is a unit-based rental subsidy program for low and moderate income individuals and families. While the Housing Authority administers the program, HUD

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

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

Resources
http://www.hud.gov/offices/pih/programs/hcv/index.cfm
Describes federal Housing Choice Voucher programs.

http://www.hud.gov/offices/hsg/mfh/progdesc/disab811.cfm
Describes federal Section 811 Programs.

http://www.hud.gov/offices/cpd/homeless/programs/splusc/index.cfm
Describes federal Shelter Plus Care Programs

Collaboration with Department of Rehabilitation

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

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

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

Opportunities

Develop taskforces and workgroups to focus on barriers to employment. These groups should involve members of California Mental Health Cooperative Programs, the Department of Rehabilitation, local pre-vocational training programs, Mental Health service providers, local Volunteer Centers, and local employers.

Examples

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

The partnership between public mental health agencies and vocational rehabilitation provides for a wide range of individualized services that are delivered through 25 cooperative agreements. Services are consumer-driven so that consumers are central to all decision-making and service selections. Services include, but are not limited to counseling and guidance, coordination

in getting services from other agencies, vocational exploration, benefits planning and counseling, specialized employment assessments, college and university education, vocational training, job search and placement assistance, transportation, tools and equipment, work clothing, and on and off the job support.

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

Resources

Website of the California Department of Rehabilitation
http://www.rehab.cahwnet.gov/

California Worknet One-stop Career Center System
http://www.edd.ca.gov/one-stop

Collaboration with health providers

Individuals with severe and persistent mental illness have higher morbidity and mortality rates than the general population. This is a result of factors directly related to their illness such as side effects of medication - including diabetes and obesity - and factors related to life style including homelessness, substance abuse, smoking, and difficulty accessing preventive care. In order to assist clients to access health services it is important to know where and how they can receive the array of services needed.

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

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

Opportunities

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

2. Develop an agreement with a nursing program to provide basic health services on site both by nurse practitioners and rotating nursing students.

Example

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

Collaboration with Educational Institutions

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

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

Opportunities

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

Examples

CalSWEC II

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

Bay Area Workforce Collaborative

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

- Development of promotional materials about the Collaborative
- Sponsorship of regional conferences on undergraduate and graduate level internships
- Promotion of the CASRA psychosocial rehabilitation curriculum and the national certification of Certified Psychiatric Rehabilitation Practitioners
- Facilitation of collaborative trainings by the Departments of Mental Health and Rehabilitation

- Support for the development of the Life High School Academy mental health program

Psychosocial Rehabilitation Training
Educational opportunities, specifically designed to train individuals in psychosocial rehabilitation have been developed with input from mental health providers, consumers, and families. The California Association of Social Rehabilitation Agencies (CASRA) has developed a 5 course curriculum in recovery-oriented, psychosocial rehabilitation practice. Designed for implementation at the community college level, it can also be used as the basis for in-service training and has been adapted for use in masters of social work programs. The five courses are: 1) Introduction to Social Rehabilitation; 2) the Helping Relationship; 3) Rehabilitation and Recovery; 4) Community Integration; and 5) Fieldwork Seminar.

The content of the coursework was developed with a group of people who practice psychosocial rehabilitation, including consumer providers. The process included identifying the core competencies needed for a person to work effectively. An advisory committee reviewed the competencies which were then used to identify course content.

Re-training programs
Educational institutions can be involved in re-training efforts as well. Courses in psychosocial rehabilitation can be offered both for college credit and continuing education hours. Courses can be offered through continuing education at times and places to meet the needs of persons already working in the field.

Collaboration with Law Enforcement

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

- A study found that men involved in the mental health system over a five year period were four times as likely to be incarcerated as men in the general population; for women the ratio was six to one.
- The Los Angeles County Jail holds more people with mental illness on any given day than any hospital in the United States.
- Nearly three-quarters of inmates with mental illness have a co-occurring substance abuse problem.
- Inmates with mental illness in state prison were 2.5 times as likely to have been homeless in the year preceding their arrest than inmates without a mental illness.
- Nearly half the inmates in prison with a mental illness were incarcerated for committing a nonviolent crime.
- On average, inmates with mental illness serve a longer portion of their sentence than inmates without a mental illness.

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

Opportunities

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

DRAFT 03/1/06

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

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

Characteristics of successful partnerships include:

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

Program Benefits:

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

Action Steps

- Identify a law enforcement department (city police, county sheriff or transit police) where community demographics reflect a high number of persons who are homeless or transient.
- Develop a central contact person in that department who is interested in working with mental health and is willing to advocate with policy makers.

- Identify an outreach worker from a mental health program to liaison with law enforcement.
- Identify a program model that all parties agree to work with
- Develop training materials for use with law enforcement or contact the State Police Officer Standards and Training (POST) department for certified training modules.
- Evaluate training materials already available for suitability such as the "Crisis Intervention Training" developed by the Memphis Police Department.[20]
- Identify barriers to successful implementation of a mental health – law enforcement collaboration.

Examples

Orange County Health Care Agency AB2034 Program
Annette Mugrditchian, LCSW, AB2034 Coordinator (714) 517-6320

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

Santa Ana Police Department
Corporal Fortino Gallo (714) 565-4030

San Jose Police Department and Ventura Police Departments
Crisis Intervention Teams (CIT, "Memphis Model")

[20] The Memphis Police Departments Crisis Intervention Team is a unique collaboration between law enforcement, crisis intervention personnel, and community mental health. More information can be found at http://www.memphispolice.org/Crisis%20Intervention.htm.

DRAFT 03/1/06

FOCUS ON COMMUNITY

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

Community Integration

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

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

Community Development

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

*http://www.communityactivators.com/downloads/StrategicCommDev.pdf Community Activators article "Strategic areas for increasing community development capacity in social service organizations"

**http://www.communityactivators.com/downloads/SeedsForRecovery.pdf Community Activators booklet "Seeds for Recovery: "Using Core Gifts to Inspire Hope and Action" gives an overview of the meaning and use of core gifts.

Preparing the Community by Fighting Stigma and Discrimination

DRAFT 03/1/06

"Many of the problems confronting people with mental illness result from public misunderstanding about psychiatric disorders. At the most harmful levels, these misunderstandings rob people of rightful life opportunities. At more benign levels, they result in a failure to prioritize mental health issues in the political arena. In either case, the *disparity* between what is available and what is provided to people with mental illness is significant and motivates the advocate to change the existing state of affairs. Many barriers cause this disparity; prominent among these is inaccurate knowledge, understanding, and perception of people, their mental illnesses, and the breadth of services available to help them. Public ignorance translates to stigma, prejudice, and discrimination that permeate common assumptions about mental illness and undermines equal opportunities." (Pat Corrigan)

Replace the Attitude

"If individuals in targeted power groups had more positive expectations about people with mental illness, then many of the goals blocked by this group would diminish. In particular, landlords who endorse positive expectations about independent living and employers who agree that people with mental illness can be competent workers would lead to a living wage, meaningful occupation, and comfortable housing for many more people with mental illness. A combination of two strategies…-contact and education- will help achieve these goals when presented to groups of landlords and employers. People with mental illness telling their stories to landlord and employer groups, especially focusing on the myths of mental illness and corresponding facts that challenge them, can have significant impact. Contact effects are further enhanced when the person telling his or her story is actually from the landlord or employer's community. The short-term impact of the person's story is further enhanced if some kind of mechanism for ongoing interaction is formed. Fort example, the employer group might start an action committee comprising people with mental illness and employers who will work as peers to rectify disparities in their community." (Pat Corrigan)

Attitude Be Damned; Stop the Behavior

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

will not provide support in the upcoming election unless certain messages change. Both these approaches are largely reactive, requiring specifically crafted messages to the businessperson or politician that convey group dissatisfaction and subsequent consequences. Advocates need to work now to recruit more people of like mind to join the effort so that their economic and political base will broaden and be in place when protest is needed. Advocates also need to educate the public as to the size and potency of this kind of coalition." (Pat Corrigan)

Action Steps

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

(Pat Corrigan)

Community Service Projects that provide Contact with People

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

Action Steps

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

Examples

S-Cubed – Contra Costa County, Ca

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

Make A Difference Day**

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

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

Resources

Corrigan, Patrick W. "Beat the Stigma and Discrimination! Four Lessons for Mental Health Advocates" University of Chicago Center for Psychiatric Rehabilitation and The Chicago Consortium for Stigma Research. Can be found at www.CASRA.org/advocacy

http://www.adscenter.org/
Website for the SAMHSA funded, Resource Center to Address Discrimination and Stigma (ADS Center). The website offers resources to implement Anti-Stigma Campaigns, including the Eliminating Barriers Initiative (EBI).

http://www.stampoutstigma.org
Describes the Stamp Out Stigma program that provides panel presentations of consumers to tell their stories and interact with audiences.

http://www.mhasd.org/About_Us/Local/Education/education.html
Erasing The Stigma of Mental Illness (ETS) is a public-private partnership to change the way the world views mental illness. Founded by the Mission Valley East Rotary Club and administered by MHA, ETS educates interested business and community leaders about mental illness and gets them involved in their own communities.

DRAFT 03/1/06

APPENDIX A

Resources

Resources

Advance Directives

http://www.bazelon.org/issues/advancedirectives/faq.htm
Frequently Asked Questions about Psychiatric Advance Directives on the Bazelon Center fro Mental Health Law website. Forms that can be used to create Advance Directives are on the website.

http://www.power2u.org/selfhep/directives_work.html
Fisher, Daniel "Making Advance Directives Work for You" on the National Empowerment Center website

http://www.power2u.org/selfhep/directives.html
Williams, Xenia "Advance Directives Are What You Make Them" on the National Empowerment center website

Employment Resources

http://www.bu.edu/cpr/catalog/multimedia/getkeepv.html
Anthony, William - video about the "Choose, Get, Keep" approach to vocational programming

http://www.apse.org/
APSE: The Network on Employment – a membership group that provides advocacy and training in the integration of persons with disabilities into the workforce.

http://www.bu.edu/cpr/latino/CAGfinalreport7-2002.pdf
Community Action Grant for Systems Change – Phase II Final Report. The Choose-Get-Keep Approach to Vocational Rehabilitation for Latinos with Co-Occurring Disorders, July 11,2002

http://www.socialsecurity.gov/work/Ticket/ticket_info.html
Information about the "Ticket to Work Program" for people with disabilities wanting to return to work.

http://www.jan.wvu.edu/
Job Accommodation Network provides information to employers and consumers in developing effective Reasonable Accommodations.

http://www.pai-ca.org/PUBS/542901.pdf
The Ticket to Work and Self-Sufficiency Program – "The Ticket" on the Protection and Advocacy Incorporated website provides basic information about this work incentive program.

http://www.yourtickettowork.com
Website created by the National Alliance for Ticket to Work to provide information and resources related to the Ticket to Work Program.

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Integrated Dual Diagnosis Treatment

http://www.kenminkoff.com/ccisc.html
Dr. Minkoff presents a description and principles of the Comprehensive, Continuous, and Integrated System of Care (CCISC) for dual diagnosis treatment.

http://www.comm.psych.pitt.edu/finds/dualdx.html
Principals for the Care and Treatment of Persons with Co-Occurring Psychiatric and Substance Disorders as endorsed by the American Association of Community Psychiatrists.

Peer Run Drop-In Centers

http://www.banmhc.org/html/index.html
Bay Area Networks of Mental Health Clients includes a directory of Bay Area Peer Run programs.

http://www.mooddisorderscanada.ca/selfhelppub/docs/campbell-leaver2003.pdf
Campbell, J. & Leaver, J. "Emerging New Practices in Organized Peer Support (2003) Report from NTAC's National Experts Meeting on Emerging New Practices in Organized Peer Support March 17-18, 2003, Alexandria, VA"

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Project Return: The Next Step offers Self Help Clubs, a Warm Line called the Friendship Line, Community activities, Discovery centers, employment, advocacy and Japanese consumer exchange.

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DRAFT 03/1/06

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CIMH Recovery Project, Focus Groups: Alameda, Contra Costa, Stanislaus, and Solano Counties Report

Community Activators and MHA Village "Recovery Oriented Leadership"

Contra Costa County Mental Health Recovery Task Force, "The Recovery Model: A Conceptual Framework and Implementation Plan", 2000

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Deegan, Patricia E., "Recovery as a Journey of the Heart", 1995

Deegan, Patricia E., "Reclaiming your Power During Medication Appointments with Your Doctor"

Farkas, Marianne & Gagne, Cheryl, Boston University, "Integrating Recovery into an Existing Program", 2001

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National Association of State Mental Health Directors website has an e-Report on Recovery with links to other national resources

http://www.power2u.org
National Empowerment Center website. A variety of articles and audio/video materials on mental health recovery.

http://www.patdeegan.com/
Discussion about recovery, video Inside/Outside.

http://www.mentalhealthrecovery.com/

Website of Mary Ellen Copeland, developer of the Wellness Recovery Action Plan. A variety of useful products for sale, and a resource page with many links.

http://www.village-isa.org/Overview/overview.htm
An overview of the The Village ISA, model strengths based mental health program.

http://www.namiscc.org/MentalHealthRecovery.htm
A collection of articles and transcripts of presentation about Recovery collected by NAMI of Santa Cruz County.

http://www.recovery-inc.com/
Website of Recovery, Inc a self help program created by Dr. Abraham A. Low which utilizes Recovery Method techniques in a self help support group setting to assist group members with "nervous symptoms."

http://www.miepvideos.org/shop/
A selection of recovery and PSR related videos useful for consumers, families and professionals from The Mental Illness Education Project, Inc.

http://www.healthyplace.com/Communities/Depression/mhrecovery/index.asp
The HealthyPlace. Com Depression Community – resources, forums, and chat.

http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/MHSIPReport.pdf
Mental Health Recovery: What Helps, What Hinders – A National Research Project for the Development of Recovery Facilitating System Performance Indicators. Stephen J. Onken, Jeanne M. Dumont, Priscilla Ridgway, Douglas H. Dornan, Ruth O. Ralph for the National Technical Assistance Center for State Mental Health Planning

http://www.miepvideos.org/recovery/mental_health_recovery.html
The Mental Illness Education Project has a produced collection of videos and books for sale.

http://www.mentalhealth.org/publications/allpubs/SMA05-3982/FREE_TO_CHOOSE_CDI_Manual.pdf
Free to Choose: Transforming Behavioral Health Care to Self-Direction (SMA05-3982) Report of the Consumer Direction Initiative Summit 2004. Self Direction and Self Directed Care are important aspects of recovery.

Resilience – Adults

http://www.bu.edu/resilience/
Institute for the Study of Human Resilience, Boston University. Courtenay Harding and Pat Deegan. Articles on providing for evidence of resilience in MH clients.

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

http://psychologytoday.psychtests.com/tests/resilience_access.html
Psychology Today Resilience test $9.95

http://pages.hosting.domaindirect.com/naturalhealthperspective.com/resilience/
Natural Health Perspective with a goal of living to age 100, somewhat preachy approach to mind-body connection.

http://cms.psychologytoday.com/search/search.cgi?q=resilience
This is the result of a search through Psychology Today articles on Resilience. Descriptions and stories of resilience and "how to" articles.

http://www.onlineopinion.com.au/view.asp?article=1847
Good overview of the pioneers in Resilience research and the progression of thought on the concept.

Resilience - Youth

Henderson, Nan "The Resiliency Quiz" at
www.resiliency.com/htm/resiliencyquiz.htm

http://www.preventionworksct.org/infostats/resresearch.html
A brief summary of Emmy Werner's work, for which she is known as the "Mother of Resiliency."

www.projectresilience.com
A website of the Project Resilience that teaches a strengths-based approach to education, treatment, and prevention. They believe that resilience can be learned. The website has information about core concepts, articles and training products.

http://resilnet.uiuc.edu/
A website of the ResilienceNet offers bibliographies, internet resources

http://www.resiliency.com/

DRAFT 03/1/06

Presenters (Nan Henderson), training and books from Resiliency in Action, Resilience Quiz, online forum, Four Steps to Resiliency pamphlet. Based in San Diego.

http://education.umn.edu/CAREI/Reports/Rpractice/Spring97/framework.htm
Research/*Practice,* Volume 5, Number 1, Spring 1997 the journal of the University of Minnesota, College of Education and Human Development, Center for Applied Research and Educational Improvement. This online issue focuses on Resilience and includes an article on Resilience and Traditional Native culture.

http://www.ncrel.org/sdrs/areas/issues/educatrs/leadrshp/le0win.htm
NCREL Monograph: Developing Resilience in Urban Youth by Linda F. Winfield, 1994, annotated bibiliography.

http://www.ncrel.org/sdrs/cityschl/city1_1b.htm
Resilience Research: How Can It Help City Schools? The Shift to a Resilience paradigm at Hiawatha Elementary School in Minneapolis. A good overview.

http://resilnet.uiuc.edu/library/grotb95b.html
A Guide to Promoting Resilience in Children: Strengthening the Human Spirit by Edith Grotberg number 7 in of a series of papers on early childhood development offered through the Bernard van Leer Foundation. Provides age specific ways for family and caregivers to help.

http://ohioline.osu.edu/b875/index.html
Fostering Resilience in Children from the Ohio State University Extension, Bulletin 875-99 – includes factors and ways to foster resilience, bibliography.

http://www.mentalhealth.samhsa.gov/schoolviolence/5-28Resilience.asp
SAMHSA's Mental Health Information Center, Working Paper Draft, 5/28/99 on Resilience, research and research based programs on resilience, bibliography.

http://neahin.org/programs/mentalhealth/stressguide.htm
Embracing Resilience in an At Risk World Free training tools, audio and powerpoint presentations through the National Education Association, Health Information Network

http://www.tcd.ie/Social_Studies/gillpub1.htm
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http://www.hec.ohio-state.edu/famlife/bulletin/volume.4/bull41xx.htm
Human Development and Family Life Bulletin, A Review of Research and Practice, Volume 4, Issue 1, Spring 1998 this issue focuses on Resilience with

an article, Resilience from Poverty and Stress– which gives a good overview of resilience. By Kimberly A. Gordon Rouse, Ph.D. in

http://www.wested.org/online_pubs/resiliency/resiliency.chap1.pdf
Chapter one "Resilience: A Universal Capacity" of a book on Resiliency that presents several concepts clearly.

Resilience - Youth and Family

http://www.clemson.edu/fyd/family_life.htm
Ways to strengthen the family to cope with change.

Stigma/Discrimination Campaign Resources

http://www.stampoutstigma.org
Describes the Stamp Out Stigma program, which provides panel presentations of consumers to tell their stories and interact with audiences.

http://www.stampoutstigma.org/documents/TrainerGuide.pdf
A guide for setting up your own Stamp Out Stigma presentations.

http://www.mhasd.org/About_Us/Local/Education/education.html
Mental Health Association in San Diego County program has an **Erasing the Stigma of Mental Illness (ETS).** ETS is a public-private partnership to change the way the world views mental illness. Founded by the Mission Valley East Rotary Club and administered by MHA, ETS educates interested business and community leaders about mental illness and gets them involved in their own communities.

http://www.adscenter.org/
Website for the SAMHSA funded, Resource Center to Address Discrimination and Stigma (ADS Center). The website offers resources to implement Anti-Stigma Campaigns, including the Eliminating Barriers Initiative (EBI).

http://www.stigma.org/
A United Kingdom group dedicated to combating Stigma. They have a Stigma Statement of Rights on their website.

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National Resource and Training Center on Homelessness and Mental Illness – Publications regarding homeless outreach and advocacy, toolkits
http://www.nrchmi.samhsa.gov/publications/default.asp
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