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A CALL FOR CHANGE

*TOWARD A RECOVERY-ORIENTED
MENTAL HEALTH SERVICE SYSTEM
FOR ADULTS*

**A CALL FOR CHANGE:
TOWARD A RECOVERY-ORIENTED
MENTAL HEALTH SERVICE SYSTEM
FOR ADULTS**

**A PUBLICATION
OF THE
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A Message from Joan Erney

It is with great optimism that I present *A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults*. As I traveled around the state recently participating in the Service Area Planning meetings, it became clear to me that we are in the midst of an exciting awakening of hope, realization, and change. The meaningful stories, the emerging leadership, and the compelling impact that a strong consumer voice is having across this Commonwealth is already in evidence. This document is meant to serve as a further tool to move us toward our statewide vision that assures that every person will have an opportunity for growth and recovery.

I wish to thank the many individuals who stimulated our thinking and committed to the hard work of developing this document, especially the work of the OMHSAS Advisory Committee Recovery Workgroup. *A Call for Change* clearly represents and honors the voice of individuals who are experiencing recovery and their undying advocacy to establish the realization nationally and in Pennsylvania that recovery from mental illness happens! Recovery is the goal!

A Call for Change establishes a firm foundation for the Pennsylvania transformation to a recovery-oriented mental health system. It offers an understanding of how we've arrived at this time of recovery transformation, provides a concise definition of recovery, and further consideration of what a recovery-oriented system is and is not. Indicators are provided to serve as critical reference points for services, agencies and county mental health programs looking for more specific strategies for transforming to more recovery-oriented services. *A Call for Change* highlights the challenges we have yet to address and the need for us to engage in open, honest discussion and debate about these issues.

Most importantly, we are called to take the steps and risks associated with true transformation. As noted by William A. Anthony, PhD., "Massive system changes must occur if the vision of recovery is to become a reality for an ever-increasing number of people with severe mental illnesses. For this very different vision to become reality, brilliant leadership is required." *A Call for Change* recognizes and calls upon the brilliant leadership of all who are part of our system – consumers, family members, advocates, providers, policy-makers and administrators – to effect true transformation in Pennsylvania.

OMHSAS is dedicated to building on the foundation of *A Call for Change*, so that the opportunity of recovery is fully supported for all who are served in our public mental health system. We look forward to your dedication in working with us to achieve this goal.



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Why a Call for Change?

The goal of a transformed system: Recovery¹

“Tangata Whai Ora”: A term chosen by and used for people with experience of mental illness or distress in New Zealand. Translated, it means “people seeking wellness”.²



Introduction

We have all seen them – those pictures of people confined to locked wards of rambling old hospitals, the hopeless look in their eyes, abandoned by family and friends, and facing a future that is bleak and desolate. It doesn't matter how old those pictures are, the 1880's, the 1940's, the 1970's, the eyes are still the same. At different times, there have been waves of reform to improve conditions, to institute more effective treatments, to seek new ways to promote and support healing from psychiatric disorders. We have found new, more helpful medications; we have helped people move from institutions to settings in our communities; we have found ways to help people find jobs or go back to school. We believe we have had some success in this work. Moreover, to some degree we have. Too often, the eyes are still the same. People are still disconnected from family and friends, isolated within their communities, and too often, trapped in assumptions about bleak futures due to perceptions of chronicity and disability.

During the past decade, many voices have risen to challenge some of the basic assumptions about mental illness and its impact on the lives of individuals and their families. People with serious mental illnesses do, in fact, recover. Some become fully symptom-free with time, while others live rich and fulfilling lives while still experiencing some psychiatric problems. The amalgamation of these voices has created what is now known as the “recovery movement” in mental health. One of the basic premises of this movement is that the role of a mental health service system is not to “do for” or to “do to”, but to “do with” – recognizing a fundamental shift in roles, power, and responsibility for providers and consumers alike. It is not about units of care, placement, or “functioning” or even a cure *per se*; it is about building real lives. It is both a goal or destination and a continuous, very human, process of growth, change, and healing.

The recovery movement is having an impact on mental health systems at all levels by challenging mental health providers, administrators, policy-makers, funders, workers, and

¹ New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

² New Zealand Mental Health Commission. (undated). See <http://www.mhc.govt.nz>.

the people who experience mental health problems and their families to look at how negative or limiting assumptions are driving approaches to services, to funding, to treatment, to policies, and ultimately to the course of individual lives. The federal government has issued a call for sweeping transformation of the mental health service system throughout the United States. In Pennsylvania, this document, *A Call for Change: Toward a Recovery-Oriented Mental Health Service System*, carries this same mandate for change into the Commonwealth, building upon our current efforts, and providing a foundation for further reflection, discussion, planning and ultimately our transformation to a more recovery-oriented mental health service system for adults in the Commonwealth.

Drawing from the experiences and ideas of Pennsylvanians, as well as contemporary literature and the experience of other states in tackling these changes, *A Call for Change* presents what we currently know about the elements of a recovery-oriented mental health system and presents a set of indicators by which the process and outcomes of transformation may be evaluated. OMSHAS expects that this document will help to articulate a more detailed vision of what a recovery-oriented system will look like in Pennsylvania at the state and local levels, and introduces the *Call to Action* in order to more strategically define the necessary steps for transformation.

In November 2004, the Pennsylvania Recovery Workgroup generated the following definition of recovery to guide service system transformation in this State. In 2005, the Pennsylvania Office of Mental Health Substance Abuse Services (OMHSAS) gave full endorsement to the definition.

Recovery is a self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.

Operationalizing this definition of recovery throughout the Pennsylvania public mental health service system for adults is the prime goal and vision of this document.

Envisioning a Transformed System in Pennsylvania

OMHSAS Vision & Guiding Principles

In 1995, Deputy Secretary Charles Curie developed the first OMHSAS mission statement that included an expectation that every person served within the system will have the opportunity for recovery. In 2003 under the leadership of Deputy Secretary Joan Erney, OMHSAS, with input from representatives

OMHSAS Vision

Every individual served by the Mental Health and Substance Abuse Service system will have the opportunity for growth, recovery and inclusion in their community, have access to culturally competent services and supports of their choice, and enjoy a quality of life that includes family and friends.

of all major stakeholder groups, developed a recovery-focused vision statement of a transformed service system in Pennsylvania.

To support this vision, OMHSAS also identified a core set of guiding principles that outline primary tenets that are to be reflected in all change initiatives. These guiding principles follow.

Guiding Principles

The Mental Health and Substance Abuse Service System will provide quality services and supports that:

- Facilitate recovery for adults and resiliency for children;
- Are responsive to individuals' unique strengths and needs throughout their lives;
- Focus on prevention and early intervention;
- Recognize, respect and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity and sexual orientation;
- Ensure individual human rights and eliminate discrimination and stigma;
- Are provided in a comprehensive array by unifying programs and funding that build on natural and community supports unique to each individual and family;
- Are developed, monitored and evaluated in partnership with consumers, families and advocates;
- Represent collaboration with other agencies and service systems.

Role of the OMHSAS Advisory Committee and the Recovery Workgroup

In May 2004, OMHSAS redesigned its Advisory Committee Structure to be more inclusive and more responsive to the various stakeholder groups. This re-organized structure took on the responsibilities of the previous Mental Health Planning Council, and further identified its role to provide guidance to OMHSAS on its broad behavioral healthcare mandate, which includes mental health, substance abuse, behavioral health disorders, and cross-system disability. The OMHSAS Advisory Committee membership is comprised of a diverse group of stakeholders including representatives of children, adolescents, older adults, and adult consumers of mental health services and their family members, persons in recovery from addictions, persons with co-occurring mental illness and substance abuse, providers, advocates, and government officials.

Recognizing the emerging need and growing interest in Pennsylvania to make a shift towards a more recovery-oriented service system, the Advisory Committee formed a Recovery Workgroup. The task of this workgroup was to explore how to transition the Pennsylvania mental health system into a more recovery-oriented approach. OMHSAS

assigned this task as a Priority Project, and approval was given by the Advisory Committee with a specific charge “to develop a blueprint to help frame and guide the transformation”.

In November 2004, the Recovery Workgroup was convened, by invitation, to discuss the process of developing a blueprint for building a recovery-oriented service system in Pennsylvania. The group met over two days to share ideas and develop consensus about the definition and indicators of recovery-oriented services in Pennsylvania. A contractor was engaged to draft a document based on the output of these meetings and other relevant materials. A Recovery Workgroup Steering Committee was formed to guide development of the draft and to review the document before submitting it for broader field review and comment.

Scope and Role of “A Call for Change”

A Call for Change outlines a destination and provides some guidance on ways to get there. Its purpose is to stimulate thinking, generate discussion, and serve as a foundation for more targeted strategic planning throughout Pennsylvania.

Some would want this document to be very detailed and highly prescriptive, a “how-to” guide for transforming the Pennsylvania mental health care system. Others would find that level of detail much too overwhelming and stifling. Through workgroup dialogue and process, a consensus was reached concerning the charge of “creating a blueprint.” It was determined that strategically detailing the work of transformation was going to demand participation beyond the workgroup members and indeed, beyond OMHSAS.

A Call for Change offers a basic framework for transformation, including guiding principles and indicators of a recovery-oriented system. In addition, it discusses some of the implications of these changes and recommends some approaches for using the indicators to initiate changes in local, county, and statewide systems. It is to be considered a “living-breathing” document and not a “set in stone” plan. It is anticipated that overtime it will serve as a foundation for strategic change planning at many levels, but it is not a strategic plan in and of itself. As the first phase of an ongoing process, its purpose is to stimulate discussion in all arenas and at all levels. Additional materials will need to be developed to help inform and guide the process as we shift toward a more recovery-oriented service system in Pennsylvania.

While the initial intent of this document was to encompass “recovery” in the broadest context of the service system, it soon became clear that a number of groups need focused attention. A more refined service and support array is needed than can be presented in this initial document; specifically the needs of adolescents/transition-age youth; older adults; individuals at first onset of mental illness; persons with co-occurring disorders and some cultural/ethnic groups. Additionally, active discussion is needed in understanding how the concepts of recovery apply for younger children and their families.

While mental health services are relatively new to understanding how recovery concepts may apply to psychiatric disorders, Drug and Alcohol services have long embraced the term “recovery”, and it has some specific meanings in that arena. Currently, there are some philosophical and practical differences in how substance abuse services and mental health services individually understand and employ the concepts of recovery.³ Considerably more discussion must take place in order that the two fields move toward a unified definition of recovery and more congruency in their terminology and approaches to recovery.

It is beyond the scope of this first document to be fully responsive to the barriers presented by the terminology and philosophy of these various groups. Therefore, the content of *A Call for Change* has been driven primarily by concepts emerging from the adult mental health recovery perspective and focuses only on transforming services for adults using the public mental health service system.

³ See Chapter 2 for more discussion on these similarities and differences.

The Roots of Recovery in Mental Health

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A fundamental question remains: If the purpose of the mental health system is not to help people on their path of personal recovery, what is it for?¹

One of the chief objectives...is to bring about a rational attitude toward disorders of the mind. This means teaching people to recognize early the warning symptoms of mental disease. It means also the establishment of mental health services to which people will feel impelled and be willing to go without delay for advice and treatment.²



Deep Roots and a Legacy of Reform

During the past decade, the concept and principles of recovery have emerged as a new way to understand mental health problems, treatment, and outcomes. Mental health consumers/ survivors/ex-patients have been a prime force in promoting this approach, often drawing from their personal experiences, both positive and negative, to help others understand that people can and do recover from serious psychiatric problems.

The roots for this movement toward recovery-oriented mental health services are both broad and deep. This chapter briefly explores some of these roots. They encompass not only our historical desire to understand the phenomena we term mental illnesses, but also the ongoing drive to find ways to help people who experience these difficulties. Some of our historical efforts have worked, some have not, but the process of learning is continual and continues today.

Even a cursory review of the history of mental health services in Pennsylvania shows that the contemporary concepts of recovery in mental health had their genesis decades, even centuries ago. Recovery is not really a new idea in mental health, but a re-emergence of fundamental values and long-standing knowledge about what it takes for people with serious mental illness to re-gain and live meaningful and productive lives. In many ways recovery is a return to basics, enhanced by the phenomenal contributions of science, research, and understanding.

Strong leadership, advocacy and innovation have established a legacy of reform in Pennsylvania that can be traced to the colonial period. Over 200 years ago, Dr. Benjamin Rush of Philadelphia, now considered to be the “Father of American Psychiatry”,

¹ Jacobson, N. & Curtis, L.C. (2000). Recovery as Policy and Practice: How States Are Implementing the Concept. *Psychosocial Rehabilitation Journal*. 23:4, 333-341. 2000.

² Beers, C. (1908). *The Mind that Found Itself*. New York: Longmans, Inc.

recognized that psychiatric illness could be diagnosed and treated, emphasizing that considerate treatment of people with mental illness could be much more effective than the rough modes then prevalent. Another innovative and early Pennsylvania leader, Thomas Kirkbride developed an approach to treatment that included not only medical services, but also therapeutic treatment which included attention to physical health and comfort, well being, industry, activity, fresh air, and other considerate therapies.

The roots of recovery draw not only from medical and biologically driven knowledge; they also reach into sociological and psychological research, humanitarian values, civil rights, social movements, spiritual elements, and even political and economic arenas. The experiences of individuals and families who have lived with mental illness, however, form the bedrock of the movement toward more recovery-oriented mental health systems.

Views of Recovery

For the past two decades, there has been increasing interest about the concept of “recovery” as it applies specifically to mental health – and increasing confusion about what it means.

Recovery has traditionally been a biomedical term relating to resolution of acute episodes of illness, distress, or disruption. In this context it implies “cure”. In the medical arena, when the term recovery is applied to long-term or chronic disorders such as diabetes, asthma or many physical disabilities it does not imply cure, but rather a return to full or partial functioning in most aspects of one’s life. In this context, the process of recovery may also imply acceptance of and adjustment to limitations and losses. Resiliency is a related concept, relevant to both adults and children, which implies the ability to manage and rebound from stress, trauma, tragedy, and other life adversities.

The term recovery can also include the act of “gaining,” as in recovering something that was lost – a sunken treasure, a sense of personal comfort or safety, confidence in speaking out, a new lease on life, and so forth.³ In a broad sense, to be “in recovery” refers to the active, uniquely personal process of finding ways of resolving or managing physical, emotional, behavioral, spiritual, or interpersonal issues that cause problems or pain, and simultaneously learning or creating a more positive, constructive, functional, meaningful, and ideally satisfying way of being. Regardless of the definition, the concept of recovery implies a dynamic, multi-dimensional, often non-linear and very individual healing process.

Research & Longitudinal Studies

The fact that people can and do recover from serious mental illness was first met with suspicion by professional service providers who provided example after example of persons with perceived chronic, life-long and disabling disorders. The concept continues to be the focus of considerable dialogue and debate in both the mental health and the substance abuse communities. The anecdotal database of consumer stories was

³ See Davidson, et al. (in draft) for a more in-depth discussion of various concepts of recovery in behavioral health.

substantiated with the findings of research conducted by Courtney Harding and her colleagues on the longitudinal course of schizophrenia.⁴ This research confirmed and amplified the findings of other international studies: the majority of people diagnosed with schizophrenia can and do recover.⁵ Moreover, as the work continues, the evidence grows, our knowledge deepens, and the word is getting out.^{6 7}

Civil Rights

The contemporary application of “recovery” to the mental health context evolved in large part from the human rights movements of the 1960’s. Here, “recovery” refers to proactively taking charge of one’s life and mental health, challenging stigma and discrimination, and moving beyond perceptions of chronicity often associated with psychiatric diagnoses. The idea that people could – and did – actually, recover from psychiatric illness grew from the experiences and stories of the people who experienced recovery in their own lives.⁸ They were the first to challenge the tautological idea that if a person recovered from mental illness, then he/she had been initially misdiagnosed.

Like many other social movements of the 1960s and 1970s, consumers/survivors/ex-patients emerged as groups with a shared history of marginalization, the shared experience of ongoing stigma, discrimination, and systematized suppression of their personal civil and human rights. These voices merged to form a consumer movement that has survived many decades of derision, fear and struggle and has emerged as a powerful force.⁹ Some of the basic goals of the movement are encapsulated in the concept of empowerment and can be understood on several different levels:

- *Systemically* -- the redistribution of power held by the state and the institution of psychiatry;
- *Collectively* -- the rights of a group to express their “voice” and to significant and meaningful participation in issues of importance to them;
- *Individually* -- taking control and responsibility for one’s own life, having and expressing personal choice.

Stories of recovery through empowerment are not limited to times that are more recent. For example, Clifford Beers penned his compelling and powerful autobiography “A Mind

⁴ Harding, C. M, Brooks, G. W., Ashikaga, T., Strauss, J. S, Brier, A. (1987). The Vermont Longitudinal Study of Persons with Severe Mental Illness II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry* 144 (6), 727-735.

⁵ See for example the work of C. Harding, J. Strauss, M. DeSisto, R. Warner among others.

⁶ Davidson, L., Harding, C., Spaniol, L. (2005). *Recovery from Severe Mental Illness: Research Evidence and Implications for Practice*. Boston: Trustees of Boston University, Center for Psychiatric Rehabilitation.

⁷ Ralph, R.O. & P.W. Corrigan. (2005). *Recovery in Mental Illness: Broadening our Understanding of Wellness*. Washington, DC: American Psychological Association.

⁸ See, for example the writings of Deegan, Fisher, Chamberlain, among many others.

⁹ Van Tosh, L., Ralph, R., Campbell, J. (2000). The Rise of Consumerism. *Psychiatric Rehabilitation Skills*. 4:3, 383-409.

that Found Itself” in 1908. Based on his experiences as a patient in various psychiatric hospitals and in community situations, he understood that a larger voice was needed in order to challenge beliefs, change conditions, and create opportunities for persons with mental illnesses. To further his vision, he created the National Committee for Mental Hygiene, the precursor to the contemporary National Mental Health Association.

Pennsylvania Consumer/Survivor/Ex-patient Movement

Self-Help and Advocacy

The mental health consumer/survivor/ex-patient (C/S/X) self-help movement began in Pennsylvania over 20 years ago. In 1984, the Mental Health Association of Southeastern Pennsylvania (MHASP) received a grant from the Philadelphia Office of Mental Health/Mental Retardation to implement a Patient Self-Help/Advocacy Organizing Project.¹⁰ MHASP hired Joseph Rogers to establish the goals of this project, bringing experience gained from his work in New Jersey and Florida where he had been involved in patient self-help movements. He organized other individuals in Philadelphia and throughout the state who provided leadership in organizing the Philadelphia and larger Pennsylvania C/S/X movements. The Involved Consumer Action Network (ICAN) lead by Mark Davis, and the Leadership, Education, Advocacy, Development project (LEAD) lead by Janet Foner were formed to establish statewide networks of consumer-run initiatives, such as self-help and advocacy groups and drop-in centers. The success of this work was seen with the establishment of strong C/S/X advocacy and self-help services not only in Philadelphia, but also in Pittsburgh, Erie, State College and Lancaster as well as more rural areas of the state.

Pennsylvania Mental Health Consumers’ Association (PMHCA)

In 1986, hope for a statewide organization to provide systems advocacy was realized with the founding of the Pennsylvania Mental Health Consumers’ Association (PMHCA), the only statewide membership association representing current and former recipients of mental health services that is governed and run by the same. Organizing activities of PMHCA have grown throughout the state and the C/S/X movement began realizing success in advocating legislatively and systemically for needed funding and development of consumer-run initiatives. Over the last 20 years, this movement has been successful in building a strong voice for increased community-based, self-help and recovery-oriented services.

National Mental Health Consumers’ Self-Help Clearinghouse

Emerging from the strong local consumer movement in Pennsylvania, the National Mental Health Consumers' Self-Help Clearinghouse received funding from the National Institute of Mental Health (NIMH) in 1986. It was the nation's first national technical assistance center focusing on the needs and interests of mental health consumers – and it was consumer run. For the past 20 years, the Clearinghouse has helped individuals, service providers, and policy-makers nationwide to understand the importance of self-help and advocacy, and has created resources and tools to help other consumers build services in

¹⁰ MHASP Lines of Communication, Sept/Oct 1984.

their areas. It continues to tackle issues relevant to mental health consumers as well as providing assistance to self-help groups and other peer-run services for mental health consumers.¹¹

Consumer/Family Satisfaction Teams (C/FST)

Pennsylvania consumer and family leaders created the innovative Consumer/Family Satisfaction Team (C/FST) approach to provide evaluation and assist with systems change. This approach, begun in the 1990's in Philadelphia, and established as a requirement for Community Hospital Integration Projects in the Southeastern region, has spread throughout the state and served as a model for other consumer and/or family run evaluation services in other states and even internationally. Consumers and family members work as a formal team to “determine whether priority population adult behavioral health service recipients and children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families are satisfied with services and to help ensure that problems related to service access, delivery and outcome are identified and resolved in a timely manner.”¹² Today C/FSTs are operating in 62 of the 67 Pennsylvania counties and are a growing force in county quality management programs.

Community Support Programs (CSP)

Beginning in the 1970's, the federal Community Support Program initiatives of the National Institute of Mental Health (NIMH) helped to shape the emergence of community resources and services for persons with psychiatric disabilities. While these services were typically conceptualized, developed, operated, and promoted as necessary life-long supports, they also contributed to the emergence of recovery in mental health by spotlighting the value of community, relationships, and work in the lives of persons diagnosed with psychiatric disorders. Furthermore, and by demonstrating that a person's ability and potential are the result of interactions between the individual, expectations, and the environment, rather than diagnosed pathology or intensity of symptoms.¹³

Pennsylvania, with the assistance of a State Technical Assistance grant from the National Institute of Mental Health (NIMH), formed the State Community Support Program (CSP) Advisory Committee in 1984 with backing from the Pennsylvania Department of Public Welfare, Office of Mental Health. This committee became a key coalition for consumers, family members, advocates and providers to collaborate and provide a unified voice in advocating for statewide systems changes. The principles of CSP became integral to shaping Pennsylvania's existing and future mental health service system. It was emphasized that services must be consumer centered, strengths based, culturally competent, accountable, flexible, coordinated, designed to meet the needs of special populations and rely on natural supports that promote the full community integration of

¹¹ See National Mental Health Consumers Self-Help Clearinghouse: <http://www.mhselfhelp.org>

¹² PA Office of Public Welfare, Office of Medical Assistance Programs, *Guidelines For Consumer/Family Satisfaction Teams and Member Satisfaction Surveys*. Available online at: www.dpw.state.pa.us/omap/rfp/SEStndsReq/omapSESRAppl.asp

¹³ See for example: Anthony, W., Cohen, M., & Farkas, M. (1990). *Psychiatric Rehabilitation*. Boston: Center for Psychiatric Rehabilitation, Boston University.

consumers. The original Community Support System (CSS) model¹⁴ disseminated by NIMH provided advocates and planners with a guide for designing a system of services, supports and opportunities that would allow adults with serious mental illness to recover and reach their full potential as contributing members of their respective communities.

The growth of the CSP movement in Pennsylvania in the years that followed extended across the four regions of the state. Using a regional committee structure, the basic values and ideas about community support were integrated into planning and service delivery approaches around the state. The committees, along with others, have done much to advance the development of community support services such as crisis services, supported housing, case management, psychiatric rehabilitation, drop-in centers, peer support and consumer run programs. In October of 2001, the CSP wheel was modified to include the concept of recovery as central to a community support program. Further, the network of regional and state CSP committees evolved so that the membership reflected the concerns and goals of the state's diverse geographic and cultural context. As of 2003, there were 46 mental health/mental retardation programs in the 67 counties of the Commonwealth and CSP committees existed in nearly all of them.

Addictions, 12-Steps, and Mutual Support

The mid 1900's saw the emergence of a variety of self-help and 12-step programs that provided an opportunity for people with addictions and other kinds of personal difficulties to come together as peers with shared experiences and to help each other. Alcoholics Anonymous (AA) was the prototype for most of these programs and continues to influence the field of addiction treatment.

While promoting the understanding of addictions as diseases rather than weakness of will or deficiency of character, AA and other 12-step programs were the first to recognize that the traditional concepts of medical recovery were not sufficient to address how people healed from these disorders. For example, they taught that sobriety was more than mere abstinence from use of the addictive substance – that it entailed completely replacing old ways with new ways, giving up an old life and learning how to create a healthy and fulfilling life. With this approach, the concept of recovery expanded to encompass many non-medical aspects of healing: the social, cognitive, interpersonal and even spiritual elements of an individual's life. For example, a basic tenet of recovery in most 12-step programs is to initiate efforts to heal damaged relationships. Similarly, symptom remission or illness management alone is inadequate to define recovery from psychiatric disorders.¹⁵ Recovery in both addictions and mental health means learning to live a full and healthy life.

Over the years, AA and other 12-step programs have demonstrated the effectiveness of people helping each other not as experts, but as peers: peer support. It is well recognized that both people involved in peer support are positively affected in these helping

¹⁴ For example, see Turner & Tenhor, 1978; Stroul, 1987.

¹⁵ Lieberman, R.P. & Kopelowicz, (2005). Recovery from Schizophrenia: A Concept in Search of Research. *Psychiatric Services*, 56:6, 735-742.

relationships, so much so that AA strongly encourages members to become sponsors – (personal supporters and guides) for others as part of their personal recovery. Drawing from personal experience and actively helping others are well known to be powerful tools in the process of establishing and sustaining one’s own recovery. This idea has extended the parameters of peer support and now encompasses the growing belief that persons with lived experience of personal recovery are not only valued members of formal treatment services, but are often seen as necessary elements of an addictions treatment program.

Concepts such as relapse prevention were well established in addiction services before they gained traction in mental health services or for people using Wellness Recovery Action Plans (WRAP). Further, the 12-step approaches have also helped us recognize the importance of spirituality in the process of recovery for many people, something that has traditionally been outside the consideration of mental health treatment.

So, is recovery in mental health the same as recovery from addiction? There are some who consider the process of recovery from mental health issues to be identical to the process of recovery from addictions. There are many similarities to be seen, including the non-linear aspect of the recovery process – “two steps forward, one step back”, the recognition that the process is not as easy as others may think it is, the reality that people rarely do it alone successfully, and recognition that the presence of supportive others and environments can make all the difference.

Nevertheless, there are also some fundamental differences between the concepts of substance abuse and mental health recovery as they are currently understood. Some of these differences are as simple as how language is used within the respective groups, but others are more philosophically rooted. For example, one of the core differences centers around the issues of power and powerlessness. One of the primary elements of 12-step recovery is to admit powerlessness and turn one’s self and life over to the power and direction of a trusted “other” or Higher Power. In mental health recovery, the focus tends to be more on empowerment and self-determination, helping individuals to find their own voice and self-determination. This approach is based on the belief that individuals need to reclaim their own power as one of the first steps of a recovery process.

In 12-step programs, members are encouraged to label themselves as their addiction or disorder: I am an alcoholic, an addict, and so forth. In mental health recovery there is emphasis on helping individuals to move beyond the diagnostic labels that have been applied to them by service providers and others. Often individuals internalize these labels, accepting them as their primary identity and experiencing unnecessary and detrimental self-stigma, low self-esteem, and self-limitations. In recovery-oriented mental health care, individuals are encouraged to NOT identify themselves, or be identified by others, as their diagnosis: I am a schizophrenic, a bipolar, and so forth. A person may “have” a disorder such as schizophrenia or depression, but there is more to the person than this – it is not their sole defining characteristic. Another aspect of the recovery concept in mental health is that an individual may be in active recovery *and* continue to experience some ongoing or periodic symptoms or difficulties. In many substance abuse service settings a person ceases to be considered “in recovery” if he/she is no longer abstinent.

Growing Recognition and Interest in Mental Health Recovery

Gaining Footholds and Support

In the 1990s, some leaders in mental health services began to recognize that recovery was not a synonym for psychiatric rehabilitation and that recovery would become a significant and guiding vision for future mental health services.¹⁶

Mental health recovery became a more frequent topic at professional conferences and other training venues. Some states and regions began to host dialogues that brought mental health consumers/survivors/ex-patients and professional service providers together on more equal ground to talk about recovery related topics. The National Empowerment Center hosted several ‘Learning from Us’ conferences where consumer leaders were the presenters and the participants were primarily providers, curious about and or willing to learn about recovery in mental health. More service providers attended the national mental health consumer conferences, “Alternatives,” in order to listen to what consumers were saying about recovery.

Some states and counties established Offices of Consumer Affairs within their mental health services administration departments. Increasing numbers of mental health agencies began hiring C/S/X as employees to provide a wide range of services from peer support to case management, evaluation, program development and management, and staff training.

Consumer/survivors/ex-patients became increasingly involved in research as partners as well as independent researchers who design, conduct, analyze and publish studies.¹⁷ Their involvement not only challenged the established research agendas to include recovery-oriented questions and to address the elements, process and outcomes of recovery in mental health, but also helped to demonstrate that consumers make significant and enriching contributions in all aspects of mental health related research.

Gathering Momentum in Pennsylvania

While there is growing interest and support on a national level for promoting recovery – oriented approaches in mental healthcare services, there is also evidence that it has been gaining momentum in Pennsylvania.

In November 2004, OMHSAS sponsored and the Mental Health Association of Southeastern Pennsylvania coordinated the first “Recovering Pennsylvania” Conference. . The conference brought together, by invitation, a broad array of consumers, family members, providers, state and county mental health administrators and other stakeholders to explore how to move Pennsylvania’s mental health system toward one grounded in hope and recovery. One task assigned to participants was to identify the recovery-focused initiatives already underway at both a state level and in local communities. The initiatives,

¹⁶ See for example, Anthony, W. (1993). Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11-23.

¹⁷ See for example the work of Jean Campbell of the Missouri Mental Health Institute.

listed below identify those current projects. These activities demonstrate some existing understanding and commitment to recovery-focused services in each region of the State already and provide a launching point for expanding and deepening this knowledge and interest more broadly throughout the state. The movement towards a recovery-oriented system and growing interest in recovery information and training among all stakeholders is evidenced by:

- Increase in both state-level and local recovery conferences that bring together diverse stakeholders to address recovery issues.
- Formation of local, regional and statewide recovery committees and task forces.
- Increased stakeholder collaboration in planning, evaluation, and policy development.
- Leadership training for consumers to participate in shaping system of recovery.
- Participation in Real Systems Change federal grant to expand Certified Peer Specialist training program.
- Pursuing strategies to secure Medicaid reimbursement for peer support services.
- Provision of Cultural Competency training.
- New Freedom Initiative Project providing grant-funded focused technical assistance to six counties for three years.
- Support for passage of legislation for psychiatric advance directives.
- Development of Pennsylvania Recovery Organizations Alliance (PRO-A), new addiction support group in Pennsylvania focused on education, advocacy and public policy.
- Anti-discrimination/anti-stigma initiatives.

Examples of local recovery initiatives from around the state include the following:

- Expanding Consumer/Family satisfaction initiatives.
- Developing certified peer specialist programs; peer mentor programs; warm lines.
- Increasing appointments of consumers to boards and committees, including to the Board of Trustees of Allentown State Hospital.
- Holding Recovery dialogues and “trialogues” – organized discussions on recovery.
- Training individuals in Wellness Recovery Action Planning (WRAP).
- Using reinvestment dollars for recovery-oriented initiatives.

On the National Scene

Many Calls for Change

Many government studies have stated the need for the same changes to be made in the behavioral healthcare service system. In 2003, the federal Veteran’s Administration

released an Action Agenda stating that recovery should be the core principle of system change of services for veterans.¹⁸ In addition, a 2000 report from the National Council on Disabilities focuses on the critical role that consumers and people who are in recovery from mental illness should play in the service system development and administration.¹⁹ In addition, the following two reports from the federal government mandate significant change – even total transformation of the public mental health service system.

Surgeon General’s Report, 1999

In 1999, the U.S. Surgeon General issued a report on mental health that for the first time on a national scale recognized the importance recovery in adult mental health, stating, “the concept of recovery is having substantial impact on consumers and families, mental health research, and service delivery.”²⁰ Recovery should be the expectation, not the exception, in mental health care.

President’s New Freedom Commission on Mental Health

In its 2001 *Interim Report to the President*, the President’s New Freedom Commission on Mental Health (NFC)²¹, described the current system of behavioral care throughout the United States as fragmented, complex, and filled with gaps, unmet needs, and barriers. For people with serious mental illness, the picture is even bleaker: high unemployment and underemployment, co-occurring substance abuse disorders are common, and disability continues. The current system is more focused on managing symptoms and the disabilities associated with mental illness than on promoting and facilitating recovery from these disorders.

In 2003, the final report of the NFC, *Achieving the Promise: Transforming Mental Health Care in America*²² called for recovery to be the “common, recognized outcome of mental health services”, stating unambiguously “The goal of mental health services is recovery”. In this report, recovery was defined as:

The process in which people are able to live, work, learn, and participate fully in their communities. For some individuals recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

The NFC Final Report outlined a vision for “a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at

¹⁸Department of Veteran’s Affairs, (2003). *Achieving the Promise: Transforming Mental Health Care in the Veteran’s Administration*. See: http://www.mentalhealth.med.va.gov/cc/text_version/October_2004.shtm

¹⁹ National Council of Disability, (2000). *From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves*. Washington, DC: Author. Available online: <http://www.ncd.gov/newsroom/publications/2000/privileges.htm>

²⁰ U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD. 1999, p. 97..

²¹ New Freedom Commission on Mental Health: *Interim Report to the President*. Available at www.mentalhealthcommission.gov/reports/interim_report.htm#p75_10348.

²² New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003. Available at www.mentalhealthcommission.gov

any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community.”

The NFC acknowledged that the current mental health service system is far from reflecting this vision and recommended fundamentally transforming how mental health care is delivered. The term “transformation” was specifically used by the Commission to reflect its belief that mere reforms to the existing mental health system are insufficient. “It is time to change the very form and function of the mental health delivery service system to better meets the needs of the individuals and families it is designed to serve”.²³

OMHSAS endorses the NFC report and calls for all counties to begin to take action to achieve transformation of their mental health services, using this document, *A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults*, as an aid to this process.

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²³ Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *Transforming Mental Health Care in America. Federal Action Agenda: First Steps*. DHHS Pub. No. SMA-05-4060. Rockville, MD. 2005.

What Does Recovery Look Like?

Recovery is variously described as something that individuals experience, that services promote, and that systems facilitate, yet the specifics of exactly what is to be experienced, promoted, or facilitated — and how — are not often well understood by either the consumers who are expected to recover or by the professionals and policy makers who are expected to help them.¹

All people with mental illness have personal power, a valued place in our families and communities, and services that support us to lead our own recovery.²



More than Treatment or Services

Recovery is construed many ways, including as an organizing principle for mental health services that is based on consumer values of choice, self-determination, acceptance, and healing.³ What distinguishes a recovery approach or “recovery-oriented services” from what is in place now? Don’t we already do this? In essence, not often. Recovery is not simply a multiple-domain treatment plan, case management, titrated medications, or job placement. Done well, all these services can help to stimulate, facilitate, and support recovery for persons with psychiatric disorders and help them to break the custodial chain between consumer and provider. However, recovery is more than treatment and services and for many, it actually happens outside the traditional mental health service arena. So, what is it?

There have been recent efforts to clarify these ideas and to build consensus around core elements of recovery from personal, programmatic, and systemic perspectives.⁴ This provides for increased understanding and consistency in the meanings of terms for policy, research, evaluation, and service development purposes.

¹ Jacobson, N. & Greenley, D. (2001). What Is Recovery? A Conceptual Model and Explication. *Psychiatric Services*. 52, 482-485.

² Adapted from New Zealand Mental Health Commission. *Our Lives in 2014: A Recovery Vision from People with experience of mental illness*. Wellington, NZ: New Zealand Mental Health Commission: 2004.

³ See for example, Davidson, et al., (in draft) and Jacobson & Greenly (2001) and the Report of the Subcommittee on Consumer Issues to the New Freedom Commission. www.mentalhealthcommission.gov

⁴ See for example, Davidson et al. (in draft); Lieberman, R.P. and Kopelowicz, A. (2005); U.S. Department of Health and Human Services (2005).

In 2005 the Pennsylvania Recovery Workgroup developed, and OMHSAS endorsed, the following definition of recovery to be the foundation for recovery-oriented activities and initiatives within the Commonwealth. The following material goes into more depth about personal, programmatic, and systemic aspects of recovery, draws from various sources, and reflects the results of consensus dialogues at the national level.

Individual

Drawing from many perspectives and resources, a recent consensus statement on mental health recovery⁵ generated by the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research, in partnership with six other Federal agencies states, that from an individual perspective,

Pennsylvania Definition of Recovery

Recovery is a self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.

Mental health recovery is a journey of healing and transformation for a person with a mental health disability to live a meaningful life in communities of his or her choice while striving to achieve full human potential or “personhood”.

Recovery is present when individuals live well and fully in the presence or absence of a psychiatric disorder. From a consumer perspective it embodies all that is necessary to manage and to overcome the psychological, physical, identity, economic, and interpersonal consequences of having a mental illness. It is also the individual person’s responsibility to him/herself, family and others, to take on the tasks of choosing, pursuing and sustaining personal recovery. This may include creating a personal crisis plan/advance directive for chosen agents or families to follow.

By all accounts, mental health recovery is a highly personal and individual process; it occurs over time, and is rarely straightforward – often characterized by steps forward and back. Recovery does not always mean that a person will live symptom free or regain all the losses incurred because of psychiatric problems. It does mean that people can and do live without feeling enveloped by mental health issues or that their potential or opportunity is curtailed because of them.

Despite the highly unique nature of each person’s journey to recovery, there are remarkable similarities that people experience in this process. Some researchers have

⁵ U.S. Department of Health and Human Services; *National Consensus Statement on Mental Health Recovery*, Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (in press)

been working to identify specific stages to the process.⁶ Identifying these similarities and stages helps us to understand the complexity of the process itself and the various ways people benefit from formal mental health services as well as other avenues for help and healing. Some people recover with minimal or even no use of mental health services. However, many, many people look to mental health services for help, hope, and pathways for healing from psychiatric disorders and the challenges in living they create.

Programs/Services

From a programmatic or service perspective, recovery-oriented services are those that are dedicated to and organized around actively helping each individual served to achieve full personal recovery. Individual recovery always happens in the context of a person's real life – not just their service environment.

For many people needing mental health treatment, however, service environments often play a critical role. Service environments and relationships with mental health workers can promote, facilitate, and support the process of personal recovery, helping persons to develop richer understanding of themselves, to take productive risks, rekindle or sustain hope, and to develop positive visions of their future. Alternatively, they also can impede, hinder or restrict opportunities for individuals to explore, to risk, to learn, and thereby limiting potential growth towards recovery. Many aspects of the traditional medical model include attitudes, practices, and policies that can cause difficulties and sometimes, significant harm to individuals searching for personal recovery.

There have been a number of initiatives, inventories, and consensus meetings in the past few years that have made great strides in naming the core attitudes and practices that distinguish recovery from more standard service approaches. The December 2004 Consensus Conference on Mental Health Recovery, sponsored by the Center for Mental Health Services (CMHS) of the national Substance Abuse and Mental Health Services Administration (SAMHSA) generated a consensus statement on mental health recovery. This document provides the following ten fundamental elements and guiding principles of mental health recovery that serve well as guideposts for recovery-oriented services.

Self-direction: consumers lead, control, exercise choice over, and determine their own path of recovery by maximizing autonomy, self-agency, and independence.

Individualized and Person-Centered: there are multiple pathways to recovery based on the individual person's unique consumer needs, preferences, experiences – including past trauma, and cultural backgrounds in all of its diverse representations. Individuals also identify recovery as being an on-going journey, an “end result” as well as an overall paradigm for achieving optimal mental health.

Empowerment: consumers have the authority to exercise choices and make decisions that impact their lives and are educated and supported in so doing.

⁶ See for example, work by Ruth Ralph; Ohio Department of Mental Health; and Andresen, Oades, & Caputi.

Holistic: recovery encompasses the varied aspects of an individual's life including mind, body, spirit, and community including such factors as housing, employment, education, mental health and healthcare services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person.

Non-Linear: recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from these experiences.

Strengths-Based: recovery focuses on valuing and building on the multiple strengths, resiliency, coping abilities, inherent worth, and capabilities of individuals.

Peer Support: the invaluable role of mutual support wherein consumers encourage other consumers in recovery while providing a sense of belongingness, supportive relationships, valued roles and community is recognized and promoted.

Respect: community, systems, and societal acceptance and appreciation of consumers - including the protection of consumer rights and the elimination of discrimination and stigma – are crucial in achieving recovery. Self-acceptance and regaining one's belief in one's self is also vital, as is respect for others.

Responsibility: consumers have personal responsibility for their own self-care and journeys of recovery. This involves taking steps towards one's goals that may require great courage.

Hope: recovery provides the essential and motivating message that people can and do overcome the barriers and obstacles that confront them.

There are increasing numbers of evaluation tools available that focus on recovery indicators and outcomes in treatment settings and services.⁷ Regular evaluation of services provides not only quality assurance, but also benchmarks for progress in transformation and a pool of evidence that demonstrates program effectiveness.

System

Mental health service systems have the responsibility to provide the leadership, direction and resources to support services and programs that help individuals experience recovery. For service systems, this responsibility includes identifying which policies, standards, and funding mechanisms restrict or interfere with services operating from a more recovery-oriented stance. The kinds of services available are dependent on what is funded. For example, peer support, crisis prevention and hospital alternatives, holistic wellness

⁷ See for example, the Recovery Oriented System Inventory (ROSI), the Healing Environments of Recovery-Oriented Services (HEROS), the Recovery Enhancing Environments Inventory (REE), and the Townsend-Hodge Becoming Recovery Focused: General Organizational Self-Assessment, and the Recovery Oriented System Assessment (ROSA), among others.

support, community education and de-stigmatization initiatives are dependent on both the systemic policies that promote them as well as funding made available to support them.

Critical policies not only include regulations, rules and service standards, but the role and process of evaluation and quality improvement within the system. The real values and definitions of quality in a service system are reflected in what is measured through its quality improvement activities. A recovery-oriented system has congruence throughout – not necessarily on specific practices or programs, but on value, desired outcomes, and a willingness to continue to seek out better ways of helping individuals with their personal recovery journey. These, however, present a challenge when it comes to measuring outcomes.

The NFC Final Report emphasizes that the goal of a transformed system is recovery. The report outlines the following six goals of a transformed and recovery-oriented healthcare system.

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

These goals are firmly based on two overarching principles, also presented in the NFC Final Report:

- *Principle 1:* Care must focus on increasing consumers' ability to cope with life's challenges, on facilitating recovery, and on building resilience.
- *Principle 2:* Services and treatments must be consumer and family centered.

Resiliency

Resiliency is a concept that initially emerged from studies of youth and families and is used to describe those individuals who seem to not only survive in difficult situations but also seem to constructively rebound from adversity. There has been some discussion in the mental health field as to whether recovery is essentially the same as resiliency. At this time, most experts view them as very different, but related constructs. The NFC Final Report defines resiliency as follows:

Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses --- and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resiliency is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments.

Essentially, resiliency is a personal characteristic that combines individual traits and learned skills; recovery is a process of positive growth, healing, and building meaningful and productive lives. Learning and developing resiliency skills (e.g. problem solving, mindfulness, and nurturing positive attitudes, managing feelings) may be important aspects of the recovery journey of many persons. The NFC states that for a system to successfully transform, “care must focus on increasing consumers’ ability to successfully cope with life’s challenges, on facilitating recovery, and building resilience, not just on managing symptoms”.

But, We Already Do That!

“But, we already do that” is commonly heard in recovery trainings and meetings for mental healthcare providers. Many providers do not see how contemporary images of recovery are different from the innovations instituted in the past decade, which included community support services, assertive community treatment, psychiatric rehabilitation and peer-support.⁸

This concern often reflects the perception that “recovery” is merely another service program or that it negates the work of past leaders and innovators. It may also embody frustration that the principles, programs, and approaches promoted in these earlier efforts were either not fully implemented or have been distorted or even lost over time.

This “yesterday’s news” sentiment challenges recovery advocates and educators to be more specific in identifying and communicating the ways in which a recovery approach is not the same as “business as usual”. The efforts of three different educators to meet this challenge are presented below to help illustrate what makes a recovery approach different from many more established service approaches.

The following chart is adapted from the work of Noordsy and colleagues, and highlights some of the basic differences between a recovery approach and more traditional services⁹

	Traditional Rehabilitation Services	Mental Health Recovery Approach
Theory	<ul style="list-style-type: none"> • Psychotic disorders produce functional impairment from which 	<ul style="list-style-type: none"> • People with “psychotic disorders” redefine themselves through roles and relationships

⁸ See, for example, Davidson, O’Connell, Tondora (in draft)

⁹ Adapted from Noordsy, D.L., Torrey, W.C., Mead, S., Brunette, M., Potenza, D., & Copeland, M.E. Recovery-oriented psychopharmacology: Redefining the goals of antipsychotic treatment. *Journal of Clinical Psychiatry*, 61(suppl 3), 22-29, 2000.

	there is no cure, but can be assisted adaptation	rather than disability
Prototype	<ul style="list-style-type: none"> • Mobility impairment • Cardiac rehabilitation 	<ul style="list-style-type: none"> • Cancer support groups • 12-step programs & other self-help approaches
Goal of service	<ul style="list-style-type: none"> • Maximize functioning • Skill development • Re-integration into society 	<ul style="list-style-type: none"> • A meaningful life
Relationship with workers	<ul style="list-style-type: none"> • Professional and client roles. Client is usually “less than” the worker • Carefully defined boundaries with minimal flexibility. “Us/Them” • Frequently “power over” 	<ul style="list-style-type: none"> • “Power with”, shared risk, and responsibility. Partnership • Meeting of “equals” with different expertise and experiences • Negotiated boundaries
Research	<ul style="list-style-type: none"> • Identify effective methods of increasing functional involvement • Models and model fidelity 	<ul style="list-style-type: none"> • Name, measure recovery process; identify predictable stages • Identification of barriers • Narrative, participatory action and first person experience • Healing cultures: the effects of relationships and environments • How recovery outcomes corroborate with health, wellness, prevention • Impact of peer support & self help • How to build, enhance, support the recovery process
Assessment	<ul style="list-style-type: none"> • Identify strengths • Elicit history, interests, and abilities. • Document capacity & disability 	<ul style="list-style-type: none"> • Consumer assessment of personally relevant consequences. Professional assessment of sense of ownership in life and desire to work/live beyond illness. Hope
Treatment	<ul style="list-style-type: none"> • Increase strengths, reduce barriers; skills teaching; Vocational rehab/work readiness • Lifestyle changes: grooming, housing, diet, exercise, substance abuse • Medications can play a vital role 	<ul style="list-style-type: none"> • Consumer driven. Worker as ally, consultant • Mutual help & self help • Seeing possibility, building hopes, dreams. • Address issues & consequences important to consumer. Taking personal responsibility • Re-defining/ re-viewing experience. Changing the way we look at things and the meaning given to them • Move from passive to active roles. Risk-taking rather than care-taking • Attention to impact of trauma as well as substance abuse issues • Conflict negotiation • Medications can play a vital role

Another set of comparisons of recovery-oriented and non-recovery-oriented service cultures comes from META agency of Phoenix, Arizona.¹⁰

Non-Recovery Culture	Recovery Culture
Low expectations	Hopeful with high expectations
Stability and maintenance are the goals	Recovery, a full life, is the goal
No clearly defined exit from services	Clear, attainable exits. Graduates return and share, become workers
Compliance is valued	Self-determination, critical thinking, and independence/interdependence are valued
People are protected from "trial and error" learning	People take risks and have the "right to fail"
One-size fits most treatment approach	Wide range of programs and non-program options
Consumers live, work, and socialize in treatment settings	Emphasis on opportunities for community linkages and building a life outside mental health treatment
Emphasis is on illness, pathology. Medication is the primary tool	Emphasis is on the whole person. Medication is one of several important tools
Once a consumer, always a consumer	Today a consumer, tomorrow a colleague

Finally, Ridgway offers a comparison of the pre-recovery mental health system and a recovery enhancing mental health system.¹¹

Pre-Recovery Mental Health System	Recovery Enhancing System
Message is: "you'll never recover" – illness is a life long condition	Message is: "recovery is likely" you can and will attain both symptom relief and social recovery
Minimal attention to basic needs	Attention to basic needs, including housing, human and civil rights, income, healthcare, transportation

¹⁰ Adapted from Ashcroft, L., Johnson, E., Zeeb, M. Mental Health Recovery, META Peer Employment Training Workbook. Phoenix, AZ: META. Undated.

¹¹ Adapted from Ridgway, P. *Research Findings: Key factors and elements of a recovery-enhancing mental health system*. Document prepared for "Recovery in Action: Identifying Factors and Trends of Transformational Systems" meeting sponsored by CONTAC and NCSTAC. Indianapolis, IN. September 21, 2004.

Focus is on person as patient, client, service recipient	Focus is on success in social roles: parent, worker, and tenant. Activities to reclaim and support a variety of social roles are emphasized
Staff primarily set treatment plan and goals with minimal input by consumer. Plans often generic and focus on illness/medical necessity of treatment	Personalized recovery plan is mandated based on person's individual goals and dreams. Plan is broad and ranging across many domains. Often includes services and resources that are not directly affiliated or controlled by mental health service system
People lack access to the most effective or research validated services	There is ready access to research validated practices and on-going innovation and research on promising approaches
Peer support is discouraged, lacking, or under funded	Peer support is actively encouraged, readily available, adequately funded and supported.
Coercion and involuntary treatment are common. Staff act "in locus parentae", over use of guardianships, rep payee and conservatorships	Coercion and involuntary treatment are avoided. People are treated as adults. Temporary substitute decision makers used only when necessary. Advanced directives and other means are used to ensure people have say even in crisis
Crisis services emphasize coercion and involuntary treatment, often use seclusion and restraint which can be (re)traumatizing	Crisis alternatives such as warm lines and respite are available. Staff has been trained to avoid seclusion and restraint and is skilled in alternative approaches
Funds are lacking for services and supports not directly related to illness	Rehabilitation oriented options are funded, flexible funds and vouchers are available, programs are response to consumer stated needs
Services often like "adult babysitting" with focus on care taking, and even child-like activities	Active treatment and rehabilitation are tailored to individual. Activities are age appropriate
Mental health workers lack knowledge and skills to support recovery	Mental health professionals and all staff are trained in rehabilitation and recovery
People held in jails without treatment	Jail diversion, mental health courts, and jail based services available
People with drug/alcohol problems are served by two systems that are often in conflict	Integrated co-occurring disorder services are readily available
Families are left out; they are not educated about recovery. Little or no family support or education	Families are educated about recovery as well as about mental illness. Family support and conflict mediation are readily available

A CALL FOR CHANGE: TOWARD A RECOVERY-ORIENTED
 MENTAL HEALTH SERVICE SYSTEM FOR ADULTS

<p>Consumers have little/no voice in system. Tokenism and exploitation. Little support for consumer input</p>	<p>Consumer voice on planning councils, consumer affairs officers, systems and program level advocacy, leadership development</p>
<p>System promoted dependence or unnatural independent. Little or no attention to social support or life after services</p>	<p>System focus on interdependence, mutual support. Attention to social network development, social integration</p>

Indicators of a Recovery-Oriented Service System

4

We have taken the people out of institutions, but we have not taken institutional thinking out of people.¹

For behavioral healthcare organizations, a recovery focus means genuine reflection about policies and practices that either enhance or detract from the individual process of recovery. It is not a new service to tack on to an existing program array... At its core recovery is about doing differently that what we must do every day.²



Recovery Is Not a New “Model”

Recovery is both misunderstood and feared at many levels. Sometimes recovery is viewed as an “add-on” service and we find “recovery teams” or programs with new names appended to them. However, at its core, recovery is not a new service tacked on to the array of more traditional mental healthcare programs. Models may come and go, but people recover. Recovery is about fundamentally doing differently those things that we do every day. Deegan contends that the focus on models is one of the largest obstacles to implementing recovery-based care, stating, “the workforce is trained to offer services according to models – and being accountable to agencies which are also organized around such models – instead of service workers being accountable and paid by the person with the psychiatric disability”.³

The recovery-orientation of a service system is determined by the degree that it exemplifies a set of tangible as well as non-tangible indicators; that their policies, practices, funding, training, evaluation, services, and values are all oriented toward helping individuals with their personal process of recovery. An orientation toward recovery is not a “model” in the traditional sense of the word in mental health and substance abuse services. Many models of service can help facilitate and support the process of personal recovery. It is not necessarily the model of service used, but how these services are

¹ Fisher, D.B. & Chamberlain, J. *A Consumer/Survivor Led Transformation of Today’s Institutionally-based System to Tomorrow’s Recovery-Based system*. Online: <http://www.mentalhealth.org/publications/allpubs/NMH05-0193> and <http://www.power2u.org/SAMHSA.pdf>

² Curtis, L.C. (2000). Practice Guidance for Recovery-Oriented Behavioral Healthcare for Adults with Serious Mental Illness. *Personal Outcome Measures in Consumer Directed Behavioral Health*. Towson, MD: The Council on Quality and Leadership in Supports for People with Disabilities.

³ Deegan, P. (2004). *Expert Panel Discusses Workforce Issues in the face of a Recovery-based Care Transformation*. In NASHPID/NTAC e-Report on Recovery, Fall, 2004.

implemented and the degree of accountability to the individuals served that distinguish recovery-oriented services from those that are not. For example, some inpatient settings are very committed and oriented toward recovery while some rehabilitation and peer-support services are oriented more toward care-taking, compliance, and acceptance of imposed limitations.

Often the challenge in recovery-oriented practices is not WHAT is being done, but HOW it is being done. Working from a recovery-orientation does not mean an “add-on” service or team, but a sincere willingness to look at the basic tasks and activities of mental health service provision and do things differently. Recovery-oriented services continue to provide basic assessment, service planning, and rehabilitation/treatment/support to individuals with a wide range of needs and fluctuating willingness to make change. They grapple with compulsory treatment and risk/safety concerns, conflicting perspectives or opinions about “best interest” or “most facilitative” practices, and so forth.

Being recovery-oriented means that a service or system makes a strong and honest commitment to a set of principles and beliefs about the ability of each person with mental health and addictions problems to grow, change, and have a life that is personally rich and fulfilling, with or without the presence of symptoms of a disorder. When services and systems make a commitment to putting these values into action, it becomes evident that many existing policies and practices are not congruent with these beliefs. The work of recovery-oriented service systems is to continually evaluate their attitudes, policies, and practices for this dissonance and to actively work to align their day-to-day activities with recovery values and principles.

Basic Domains

A considerable body of material has emerged during the past few years offering various markers of recovery oriented service systems and tools for measuring these basic benchmarks. There is a striking consistency among the various initiatives regarding the primary domains or areas that characterize a recovery-oriented service. These basic domains are as follows.

- Validated Personhood
- Person Centered Decision-Making & Choice
- Connection -- Community Integration, Social Relationships
- Basic Life Resources
- Self-Care, Wellness, & Finding Meaning
- Rights & Informed Consent
- Peer Support/Self-Help
- Participation, Voice, Governance & Advocacy
- Treatment Services

- Worker Availability, Attitude and Competency
- Addressing Coercive Practices
- Outcome Evaluation & Accountability

Within each of these broad domains are specific indicators that should be common practices in recovery-oriented systems. There are many ways each indicator can be demonstrated by individuals, by programs/services, and by the mental health authorities. The more indicators present and the more ways those indicators are manifest within a system, the more that service or system can be described as recovery-oriented.

However, these domains and indicators only tell part of the story. Often it is not just, WHAT is being done, but also HOW it is being done that makes the difference. For example, many agencies can appoint consumers or family members to policy groups or bodies, but the experience of many of these individuals is tokenism, marginalization, feeling placated and not valued as participants. Some agencies are now requiring that all consumers complete – for the file – a Wellness Recovery Action Plan (WRAP). This potentially rich and rewarding process becomes reduced to another piece of mandated and meaningless paperwork, but the organization can report that most of the people it serves have WRAPs.

While measuring specific benchmarks can be useful, it only captures a part of the story. Often it is the intangibles that make the difference between systems or services that are truly focused around helping individuals with their personal recovery and those that are going through the motions. The recognition, development and measurement of these intangibles are where Pennsylvania needs to make its mark.

Indicators of Recovery-Oriented Systems

The following tables provide a basic set of indicators of these domains. They are the heart of *A Call for Change* and serve as critical reference points for services, agencies and county mental health programs looking for specific strategies for transforming to more recovery-oriented services.

The following information presented has been derived from the considerable amount of work done by Pennsylvanians in focus groups, meetings, and formal work groups to identify the indicators of recovery-oriented services. Additionally, it includes current literature, the experience and planning activities of several states, various evaluation instruments designed to assess the recovery focus of a service or system, personal recovery or outcome assessments, and from the experience of individuals and their families.⁴ They include things identified by consumers as needed in mental healthcare

⁴ Material was drawn, for example, from the PA Recovery Workgroup, ROSA, Ridgway REE, HEROS, MSHIP, ROSI, Hodge/Townsend Recovery Readiness Scale, Recovery Education Affects Life (REAL), CT Standards of Practice for Recovery-Oriented Behavioral Health Care, NFC Report, WI Blue Ribbon Commission Report, What Helps and What Hinders Report, AACAP Guidelines for Recovery Oriented Services, MHEP Inc. White Paper,; Curtis, 2000, NASMHPD/NTAC e-Report on Recovery and so forth.

services and systems to promote and support recovery by policy-makers and consensus-bodies, researchers, as well as by those services and systems that are making efforts to become more recovery-oriented.

The tables offer some ways each indicator may be demonstrated from an individual perspective, by a service or program, and by a county, regional or state mental health authority. As presented here, the tables are incomplete – leaving room for more ideas, inspiration, and input. The tables are offered as a starting point for discussion, creative thinking, and prioritization for future strategic planning.

It should be noted that these tables do not identify the specific mechanisms and other considerations that may be pre-requisite to operationalizing these indicators in a complex service system. These prerequisites may include funding, licensure/regulation/certification, union negotiation, personnel training and supervision, interagency coordination, and so forth. These issues will need to be addressed in time through strategic planning for specific transformation initiatives.

While these activities may help stimulate, support, and facilitate the process of personal recovery among individuals served by the mental healthcare system, the bottom line is accountability to the persons served and their attainment of personal outcomes. Successful recovery-oriented systems will be able to consistently show evidence that people served are achieving personal outcomes that are meaningful to them. Unless services and the system can demonstrate that personal recovery outcomes are being attained, it is not a successful system, regardless of how many of the following factors or activities it has put into place.

RECOVERY DOMAIN 1: Validated Personhood			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual Indicator/Outcome</i>	<i>By Program/Services</i>	<i>County, Regional, or Statewide</i>
Demonstration of hope & positive expectations	<ul style="list-style-type: none"> • Staff expects that I can and will function well. • Staff believes that I can grow, change, and recover. • Workers help me feel positive about myself. • I feel confident about my abilities and myself. • People appreciate what I do. • I do things that make me feel good about myself. 	<ul style="list-style-type: none"> • Consistent use of person-first language in all written and verbal communication. • Demonstrate efforts to identify and eliminate stigma within the service system itself. 	<ul style="list-style-type: none"> • Evidence of these values and indicators in each County Annual Plan.
Evidence that consumers, workers, administrators understand recovery	<ul style="list-style-type: none"> • I am treated as a whole person, not as a psychiatric patient or label. • Staff encourages me to take responsibility for how I live. • I can attend staff trainings about topics that interest me. • I am asked to "tell my story" and to help others learn about recovery. 	<ul style="list-style-type: none"> • Evidence of explicit recovery language in mission, vision, and guiding principles documents. • Evidence of visible and immediate availability of information about recovery and recovery services/options. • Evidence of regular and ongoing recovery-education for consumers and family members. • Evidence that 100% of workers have participated in orientation training about recovery. • Evidence of policies and enforcement of policies requiring person-first, respectful language in all written and verbal communication. • Evidence of encouragement and support for "co-learning" activities where staff and consumers participate in training together. • Evidence that 100% of board of directors and administrators have participated in recovery education. 	<ul style="list-style-type: none"> • Evidence of explicit recovery language in mission, vision, and guiding principles documents. • Recovery oriented outcomes and procedures evident in all contracts, training, and policies. • Institute recovery training for administrators and staff. • Require agencies/contractors to demonstrate recovery orientation, and outcomes are requisite for all contracts and grants. • Provide opportunities for "recovery dialogues" between various stakeholder groups, including psychiatrists and consumers to move toward shared understanding. • Evidence that 100% of staff in policy and administrative organizations have participated in recovery training.
Respect for diverse cultural backgrounds, ethnicity, sexual orientation, etc.	<ul style="list-style-type: none"> • I feel my culture and lifestyle are understood and respected. • I have access to translators if needed. • I feel I can tell people about my heritage and healing traditions. 	<ul style="list-style-type: none"> • Evidence of information available in a range of locally relevant languages. • Demonstration of adaptation of services and treatment approaches to respect or support cultural differences. • Demographics of provider staff reflect race/ethnicity demographics of consumers served. 	

RECOVERY DOMAIN 2: Person Centered Decision-Making & Choice			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual Indicator/Outcome</i>	<i>By Program/Services</i>	<i>By County, Regional, or Statewide</i>
Person-centered / person-authored service planning	<ul style="list-style-type: none"> • Staff sees me as an equal partner in my treatment program. • My treatment goals are stated in my own words. • Staff respects me as a whole person. • I chose my services. • Staff understands my experience as a person with mental health problems. • Staff listens carefully to what I have to say. • Staff treats me with respect regarding my cultural background, (race, ethnicity, language, etc.) • I make decisions about things that are important to me. • I, not workers, decide what should be in my treatment plan. • I feel comfortable talking with workers about my problems, treatment, personal needs and hopes. 	<ul style="list-style-type: none"> • Inclusion of persons own language re goals, objectives, etc. Service plan clearly reflects individual's preferences, goals, lifestyle, and interests. • ROSA type assessment and dialogue – conversational, broad based, outcome focused. • ALL consumers have an in-pocket copy of their personal plan. • Individuals can easily state why they receive services, what their service/treatment goals are, and how services help them achieve those goals. • Inclusion of consumer selected others in planning process. • Ongoing discussions regarding progress and changes needed. • Evidence that consumers can change their plans upon request. • Persons have regular access to their personal records and charts upon request for both review and input. • Demonstration of creative approaches to meet individualized needs. 	<ul style="list-style-type: none"> • Mandates all contractors and local systems to demonstrate evidence of person-centered planning. • Address existing policies and standards to identify and remove barriers to person centered planning.
Service planning is built around building, enhancing, and sustaining strengths	<ul style="list-style-type: none"> • My service plan helps me build on my strengths and assets. • My provider asked who in my life is supportive of me. • I get help to prepare for and pursue employment that is acceptable and rewarding to me. 	<ul style="list-style-type: none"> • A recovery oriented service plan is negotiated and developed with each person served. • The provider uses a strength-based assessment. • Qualified individuals are employed. 	<ul style="list-style-type: none"> • Qualified individuals are employed.

RECOVERY DOMAIN 3: Connection -- Community Integration, Social Relationships			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual Indicator/Outcome</i>	<i>By Program/Services</i>	<i>By County, Regional, or Statewide</i>
Focus on community connections	<ul style="list-style-type: none"> • I have friends I like to do things with. • I have people I can count on when things are difficult. • I am free to associate with people of my choice. • I receive support to parent my children. • There is at least one person who believes in me. • I have support to develop friendships outside the mental health system. • There are people who rely on me for important things. • I have support for challenging negative stereotypes, stigma, and discrimination. • I feel comfortable interacting with businesses and organizations in my community. 	<ul style="list-style-type: none"> • Evidence that workers help individuals develop positive personal relationships. • Evidence in service plans that workers encourage and help individuals to access services and resources outside the mental health system. • Evidence that workers attend to consumers roles as regular people (e.g. parents, workers, tenants, students), not just as patients. • Signature pages in service plans often reflect participation of persons across programs, agencies, and families/friends. 	<ul style="list-style-type: none"> • Develop public education campaigns to increase awareness and reduce stigma about mental health problems. • Develop mechanisms to coordinate service systems at regional and state levels, e.g. mental health/vocational rehabilitation, public welfare services, adult basic education, faith-based service initiatives, and so forth. • Public relations activities actively promote and help others understand recovery. • Consumer success is highlighted in public education and relations campaigns. • Consumers are involved in all public education and relations campaigns.
Family Support	<ul style="list-style-type: none"> • My family gets the education or supports they need to be helpful to me. 	<ul style="list-style-type: none"> • Evidence of good working relationships with family support groups. • Evidence that consumers are encouraged and supported to involve family members and significant others in treatment decisions. • Evidence that consumers are encouraged and supported to develop constructive relationships with family members and significant others. • Families train providers about their experiences and needs. 	
Addresses issues relating to stigma and discrimination both in the community and within behavioral healthcare services	<ul style="list-style-type: none"> • Workers really believe in me and in my future. • I believe my provider helps educate the community about mental illnesses. 	<ul style="list-style-type: none"> • Evidence of staff awareness and training programs that challenge common stereotypes and assumptions about mental illness. 	<ul style="list-style-type: none"> • Evidence of staff awareness and training programs that challenge common stereotypes and assumptions about mental illness.

RECOVERY DOMAIN 4: Basic Life Resources			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual Indicator/Outcome</i>	<i>By Program/Services</i>	<i>By County, Regional, or Statewide</i>
Attention to basic material needs	<ul style="list-style-type: none"> • I have transportation to get where I need to go. • I have enough income to live on. • I believe my basic needs are met. 	<ul style="list-style-type: none"> • Evidence that agencies assist individuals with basic material needs such as transportation and income. 	<ul style="list-style-type: none"> • Individuals are paid for work by the county, region or state.
Strong focus on Work/Employment/Education and Meaningful activity	<ul style="list-style-type: none"> • I choose where I work or learn. • I have a job or work that I like doing (paid, volunteer, part-time, and full-time). • I have things to do that are interesting and meaningful to me. • I have interesting options to choose from for where I work or learn. • I have a chance to advance my education if I want to. • There are things I want to do or achieve in my life that have nothing to do with mental health treatment. • My provider believes that I can work and supports me in my efforts to obtain employment. 	<ul style="list-style-type: none"> • Attention to and evidence of wide range of work and education options. • Use of interest inventories and other career selection tools, in addition to skill assessments. • Opportunities to “job sample.” 	<ul style="list-style-type: none"> • Ensure funding for employment training and job-site support, stipends/scholarships for educational development, etc.
Securing safe, decent, affordable home/housing	<ul style="list-style-type: none"> • I choose where and with whom I live. • I have housing I can afford. • I feel safe where I live. • I feel comfortable and at home, where I live. 	<ul style="list-style-type: none"> • Active and ongoing assistance to help individuals find and keep community housing of choice. • The County has a housing development plan. 	<ul style="list-style-type: none"> • Complaints about living facilities are addressed by advocates or ombudsman.
Ensuring good physical healthcare	<ul style="list-style-type: none"> • Staff talks to me about my physical health. 	<ul style="list-style-type: none"> • Availability of regular and low/no cost physical health screenings and wellness services. 	<ul style="list-style-type: none"> • Nurses are employed to assist with health issues.

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	<ul style="list-style-type: none"> • I have access to medical benefits that meet my needs. • I have access to health services I need. • I have information about health issues that relate to me. • I have the best possible health. 	<ul style="list-style-type: none"> • Evidence that workers help individuals get healthcare benefits that meet their needs. • Evidence workers are knowledgeable about psychiatric manifestations of physical illness. • Evidence that workers “rule out” physical illness before assuming psychiatric etiology for problems. • Healthcare history is collected as part of basic assessment. • Attention to healthcare issues integrated into discussion about psychiatric services/treatment. • Evidence of worker knowledge about physiological side effects and risky interactions of common medications. • Skilled nursing staff available easily for consultation to both workers and consumers about consumer health care issues. 	
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RECOVERY DOMAIN 5: Self-Care, Wellness, & Meaning			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual Indicator/Outcome</i>	<i>By Program/Services</i>	<i>By County, Regional, or Statewide</i>
Focus on wellness/self-management	<ul style="list-style-type: none"> • Staff supports my self-care and wellness. • Staff helps me to build on my strengths. • Staff helps me explore resources for spiritual growth, if I want such help. • Services have helped me to be more independent and to take care of my needs. • I am comfortable asking for help when I need it. • I have found ways to effectively manage symptoms (of mental illness, substance abuse, and trauma) and problems in my life. 	<ul style="list-style-type: none"> • Evidence of mechanisms, training, and support for consumers to develop personal Wellness Recovery Action Plans (WRAP). • Evidence of support for and willingness to help individuals explore holistic or alternative approaches to self-care. • Evidence of regular curriculum and resources for wellness education. • Evidence that workers model good wellness attitudes and activities. • Demonstration of willingness to help individuals find ways and resources for spiritual growth. 	
Proactive crisis planning, effective response and hospital alternatives	<ul style="list-style-type: none"> • I have a say in what happens to me when I am in a crisis. • I have assistance in creating a plan for how I want to be treated in the event of a crisis, such as an advance directive. • I have a personal plan to help me and my supporters get through a crisis. • I have found ways to manage with symptoms and difficult situations that work effectively for me. 	<ul style="list-style-type: none"> • Encouragement, education, and support for consumer use of psychiatric advance directives. • Availability of respite or other crisis prevention services. • Established mechanism for helping consumers be aware, understand, and complete personal psychiatric advance directives. 	<ul style="list-style-type: none"> • Evidence of leadership in promoting and supporting advance directives. • Identification and minimization of policies or practices that may interfere with implementation of advance directives when needed. • Evidence of providers working together to assure easy maneuverability among programs. • Individuals have choice in where to receive crisis services independent of county of residence.
Attention to spirituality & finding meaning	<ul style="list-style-type: none"> • I have support and encouragement to explore and express my spirituality, if it is important to me. • I have support and encouragement to use my spirituality as a path to wellness. 	<ul style="list-style-type: none"> • Evidence of training and supervision for staff around spirituality in mental health treatment and support. 	

RECOVERY DOMAIN 6: Rights & Informed Consent			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual Indicator/Outcome</i>	<i>By Program/Services</i>	<i>By County, Regional, or Statewide</i>
Emphasis on rights and informed consent	<ul style="list-style-type: none"> • Staff gives me complete information in words I understand before I consent to treatment or medication. • My right to refuse treatment is respected. • I know my rights and what to do if they are abused. • Staff respects my wishes about who is and who is not given information about my treatment. • I receive information about my rights as a client, as a citizen, and as a human being in words I understand. • Staff “goes to bat” for me to help me protect and uphold my rights. 	<ul style="list-style-type: none"> • Provide information about individual rights. • Evidence of actively upholding, protecting, and advocating for individual rights. • Evidence that ensuring fully informed consent is day-to-day practice in all aspects of care, treatment, planning, and personal decision-making. • Promotion and support for voter registration, voting, and other civic activities. 	<ul style="list-style-type: none"> • Demonstrate development and implementation of an informed consent policy applicable to all services and programs. • Establish and ensure widespread understanding of consumer rights and responsibilities by developing a statewide consumer bill of rights.

RECOVERY DOMAIN 7: Peer Support & Self-Help			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual Indicator/Outcome</i>	<i>By Program/Services</i>	<i>By County, Regional, or Statewide</i>
Availability and support for self-help, peer support, consumer-operated services	<ul style="list-style-type: none"> • I have access to other consumers who act as role models. • There is a consumer advocate to turn to when I need one. • I am encouraged to use consumer-run programs. 	<ul style="list-style-type: none"> • At least 1% of total mental health budget set aside for development and operation of peer services. • Training and education programs available to educate and prepare consumers for employment in human service arena. • At least one independent (501-c-3) consumer operated service in each locality. • Evidence that workers are knowledgeable about peer support, self-help, and consumer operated services available locally. • Evidence that workers support and promote consumer participation in these services. • Evidence of collaborative agreements and positive working relationships between consumer operated and traditional services. 	<ul style="list-style-type: none"> • There is at least one freestanding peer/consumer operated service in each service area. • At least 1% of the total mental health budget is allocated for the development, operation, support, and evaluation of peer services.
Employment of consumers as workers in traditional and non-traditional service & administrative/ policy organizations	<ul style="list-style-type: none"> • I personally know consumers who are working as paid staff in the mental health services. 	<ul style="list-style-type: none"> • Evidence of workers at all levels of traditional and non-traditional organizations that are consumers – and “out” as personal experiences with mental illness. • Career paths open to individuals within traditional organizations. • Mechanisms for dialogue regarding challenges presented by and faced by consumer workers. • Attention to agency ethics policies and practices in light of impact of consumer workers. • Evidence of affirmative action program within organizations. • At least 5% of all staff in mental health agency are individuals who receive or received services. 	<ul style="list-style-type: none"> • Evidence of affirmative action program for hiring C/S/X into regular positions. • Evidence of advocacy for or use of Medicaid as source of funding for peer delivered services.

RECOVERY DOMAIN 8: Participation, Voice, Governance & Advocacy			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual Indicator/Outcome</i>	<i>By Program/Services</i>	<i>By County, Regional, or Statewide</i>
Active involvement of consumers and family members in advocacy, leadership, with representative voice in governance	<ul style="list-style-type: none"> • I have a say in how my agency operates. • I sometimes get active in causes that are important to mental health consumers. • If I am not happy with services or conditions, I know what to do to file a grievance or get changes made. 	<ul style="list-style-type: none"> • Evidence of consumers as voting members of governance boards, advisory committees, and formal planning groups. • Accommodation mechanisms in place to assist/support consumer involvement in boards, committees and other advisory and governance bodies. • Regular use of various input mechanisms for ideas, feedback, and complaints (e.g. surveys, focus groups, etc.) • Consumers/family members report feeling heard and respected as part of these groups and processes. • Evidence that consumer input is valued and used in decision-making and planning. • Leadership/advocacy training programs and mentorship available. 	<ul style="list-style-type: none"> • Evidence of consumers as voting members of boards, advisory committees, and formal planning groups. • Development of an “expert pool” of trained/experience consumers/families that can provide leadership/advocacy education and mentorship. • Evidence of efforts to recruit, invite, train, accommodate and support consumers and families in leadership, governance, advisory roles. • Evidence of consumer involvement in provider contract development and review. • Evidence of an “Office of Consumer Affairs”, or its equivalent, at high levels in state, regional, and local administrations.

RECOVERY DOMAIN 9: Treatment Services			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual Indicator/Outcome</i>	<i>By Program/Services</i>	<i>By County, Regional, or Statewide</i>
Access to appropriate and effective pharmacology	<ul style="list-style-type: none"> • The doctor worked with me to get me on medications that were most helpful to me. • I get information about medications and side effects in words I understand. 		
Access to range of effective treatment approaches	<ul style="list-style-type: none"> • I have good service options to choose from. • Services are helpful to me. • Services help me develop the skills I need. • Staff has up- to- date knowledge about effective treatment approaches. • I have information and guidance I want about services and supports both inside and outside the mental health agency. • I can get services when I need them. • I can see a therapist when I need to. • I have enough time to talk with my psychiatrist. 		
Availability and integration of trauma specific treatment and support	<ul style="list-style-type: none"> • I can get specialized services for past or present trauma or abuse if I need or want them. • I feel safe from violence, trauma, abuse, and neglect. 	<ul style="list-style-type: none"> • Evidence of work to identify and eliminate practices that may be re-traumatizing. • Consumer operated self-help groups for individuals dealing specifically with mental illness and trauma related issues. • Employment of staff trained in providing trauma-informed treatment. 	<ul style="list-style-type: none"> • Inclusion of trauma support services in all contracts. • Evidence of work to reform insurance and Medicaid policies that do not include trauma treatment or support. • Development and promulgation of training and technical assistance to promote trauma informed services at local/regional levels. • Establishment of Trauma Advisory Committees to better identify needs.

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			<ul style="list-style-type: none"> Evidence of efforts to improve detection and prevention of abuse in institutional settings
Integrated substance abuse services and treatment	<ul style="list-style-type: none"> I can get combined treatment for mental health and substance abuse issues. I can chose from a range of services that may help me manage substance use issues. 		<ul style="list-style-type: none"> Evidence of training for county staff about regulations and competencies for co-occurring mental illness and substance abuse disorders.
Access to jail diversion and jail-based services	<ul style="list-style-type: none"> I have access to jail diversion services if I need them. 	<ul style="list-style-type: none"> Evidence of coordination and collaboration with law enforcement services. Evidence that jail diversion services are available in the community for persons with mental health problems. Evidence that mental health services are available and delivered in jail settings. 	<ul style="list-style-type: none"> Evidence of inclusion of law enforcement and judicial personnel in county recovery efforts.

RECOVERY DOMAIN 10: Worker Availability, Attitude and Competency			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual Indicator/Outcome</i>	<i>By Program/Services</i>	<i>By County, Regional, or Statewide</i>
Ongoing attention to building worker positive characteristics and competency in recovery practices	<ul style="list-style-type: none"> Workers have up-to-date knowledge about the most effective treatments for me. I feel respected and understood by mental health workers. 	<ul style="list-style-type: none"> Evidence of establishment of recovery-oriented competencies. Evidence of recovery- oriented training included in all aspects of orientation, in-service and professional development activities. Evidence of organizational support for workers to develop and use recovery-oriented approaches. Evidence of ongoing training and supervision activities that help deepen worker understanding of recovery practices. Evidence of ongoing training in up-to-date promising and evidence-based practices. Supervision practices help workers develop and implement recovery-oriented approaches for each person served. 	<ul style="list-style-type: none"> Evidence of efforts to influence university curricula for all human service and medical fields to include recovery information as part of basic training. Establishment of core competency standards regarding knowledge of recovery principles and practices. Include recovery competencies in credentialing and certification processes. Requirement that recovery-oriented training is part of every application for continuing education for renewal of state licensure.

RECOVERY DOMAIN 11: Addressing Coercive Practices			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual indicator/Outcome</i>	<i>By Program/Services</i>	<i>By County, Regional, or Statewide</i>
Minimized use of coercive approaches (seclusion/ restraint, involuntary treatment, guardianships, payeeships, threats, etc)	<ul style="list-style-type: none"> • Staff helps me to stay out of psychiatric hospitals and avoid involuntary treatment. • Medication and treatment is not forced on me. • Staff does not use pressure, threats or force in my treatment. • If I have a payee or community commitment order, I know why and know exactly what I have to do to be released from these stipulations. • I chose how to manage my personal finances. • I am free from coerced treatment. 	<ul style="list-style-type: none"> • Data collected and tracked regarding use of coercive approaches, with feedback to individual services. • Training for staff on alternatives to coercion. • Time limited: evidence that individuals are “graduating” from involuntary care, guardianships, payeeships. • Individuals on involuntary treatment, guardianships, and payeeships know the reasons why these mechanisms are in place and what they need to do to get out from under them. • Demonstration that agencies respect and attend to the dignity and rights of individuals subjected to involuntary or coercive practices. • Evidence that every person under a coercive mechanism (payee, conditional release, outpatient commitment) has a written plan of achieving self-management in this area of his/her life. • Evidence that alternatives to involuntary treatments or coercive approaches are identified, promoted, used in services. • All data is reviewed regularly by the Board of Directors. 	<ul style="list-style-type: none"> • Evidence of mechanism to track data about incidence and prevalence of use of wide range coercive practices within system. • Transparency in data about number of clients receiving voluntary and involuntary inpatient hospitalization in public and private hospitals; involuntary outpatient commitments, etc. • Transparency in data about use of seclusion, restraint, restrictive holds in all settings. • Evidence of feedback loop to agencies, services, hospitals regarding coercive practices data. • Evidence that alternatives to involuntary treatments or coercive approaches are identified, promoted, used in services. • All data is reviewed regularly by administration, advisory committees, and other key stakeholders.
Managing risk & supporting safety for workers, consumers and family members	<ul style="list-style-type: none"> • I know what to do if I feel unsafe where I live, work, socialize, or travel. • I am aware of people, places, times, and things that cause me difficulty – my “triggers”. • I am aware of ways to handle my “triggers” that work for me. 	<ul style="list-style-type: none"> • Workers knowledgeable about assessing risk factors and probability. • Evidence of individualized approaches to managing and minimizing risk. • Availability of training and support for consumers about personal safety and develop skills for identifying and managing risk presented in their living situations/neighborhoods. 	<ul style="list-style-type: none"> • Evidence that crisis response services are available and staffed with individuals trained and competent in mental health and substance abuse crisis intervention. • Evidence of service protocols that promote mental health crisis response prior to police intervention in most mental health crisis situations.

		<ul style="list-style-type: none"> • Ensure that workers have access to regular information and training about personal safety and risk management for office and community settings. 	
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RECOVERY DOMAIN 12: Outcome Evaluation & Accountability			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual Indicator/Outcome</i>	<i>By Program/Services</i>	<i>By County, Regional, or Statewide</i>
Orientation toward continual learning and improvement through regular outcome evaluation with data used to guide positive change	<ul style="list-style-type: none"> • I achieve personal outcomes that are meaningful to me. • Workers help me recognize when I am making progress. 	<ul style="list-style-type: none"> • Personal outcomes identified and measured as evidence of progress and quality services. • Systemic outcomes evaluated regularly. • Evidence that consumers are involved in the identification of outcomes and in the process of evaluation of services. • An attitude of "catch 'em doing it right" is evidenced by workers who recognize progress and do not always focus on problems and crises. • Evidence that consumers receive regular positive feedback on progress. • All outcome data is reviewed regularly by the board of directors. 	<ul style="list-style-type: none"> • Develop or adopt standardized recovery-focused outcome measures to be used as part of regular quality assurance activities. Included in this are both personal consumer outcomes as well as service or system outcomes. • Full transparency in data collection and reporting. • Evidence that findings from outcome assessments and evaluations are used to improve services and programs. • Evidence that recovery orientation and outcomes are part of all standards, licensing, and assessments for all services. • Involve consumers in outcome evaluation in multiple roles, including developing outcome indicators, instrument development, interviewers, data entry & review, etc. • Evidence of support for continuous quality improvement at levels.

Implications of Shifting Toward a Recovery-Oriented Mental Healthcare System

5

A vision without a task is a dream and a task without a vision is drudgery – but a vision with a task can change the world.¹

Recovery is a person-centered phenomenon. You can't “do recovery” to someone. You can't “do services” that will force someone to recover. Recovery-based services will always be one small part or one small ingredient for a person with psychiatric disabilities to achieve a meaningful life in the community²

Nothing about us without us. We want to be involved at every level of decision-making; we don't want to be just relegated to an advisory board.³



Challenges and Barriers

Systems, like people, do not change easily. Every system is perfectly designed to stay exactly the way it is. For meaningful change to occur some discomfort, imbalance, uncertainty, and acceptance of risk are prerequisite.

Taking on the challenge of shifting toward more recovery-oriented approaches in our service system means making some fundamental changes in some of the core aspects of our work. In addition, there are significant challenges to be overcome. Not in the least of which is developing a common understanding about process and outcomes of recovery in mental health, generating a set of concrete indicators that represent an organization's focus on recovery and its effectiveness in stimulating, facilitating, supporting, and sustaining the process of recovery with the people it serves, and ways to measure incremental change toward these goals. Understanding these challenges and identifying strategies to address them increases the likelihood that a change strategy will result in the desired outcomes.

¹ Black Elk

² Deegan, P. (2004). *Expert Panel Discusses Workforce Issues in the face of a Recovery-based Care Transformation*. In NASHPID/NTAC e-Report on Recovery, Fall, 2004.

³ Ibid.

The 2004 Recovering Pennsylvania Conference report identified some of the fundamental challenges and barriers of moving toward a more recovery-oriented mental healthcare system in Pennsylvania. These included the following:

Fear – Providers fear of risk/liability of exploring shared or negotiated risk and consumer fear of losing services, facing stigma, losing control, of failure. A disconnect between the rhetoric of a program or organization and the actual experience of consumers, family members, and workers. Programs may talk about supporting consumer self-determination and empowerment, but refuse to allow anything risky.

Attitudes - Basic resistance to change; difficulties in trying different things, entrenched attitudes and resistance to examining assumptions; belief (by both some consumers and staff) that recovery is not possible for people with mental health problems. Recognition that recovery principles run counter to the way things operate now. Strong beliefs that people with serious mental health problems need intensive and life-long caretaking. These beliefs may be held to some degree in every corner of the system, including workers, family members, administrators, community members, and consumers themselves. Stigma and discrimination *within the system* are major impediments to change.

Knowledge and Emotions – Differing views of recovery among stakeholders. Anger and frustration. Lack of patience for change. Poor coordination, collaboration, or communication among stakeholders. Consumer beliefs that recovery is a concept that has been (or will be) co-opted by the system to justify reductions in care and services. Sometimes this has been a reality.

Providers – Lack of understanding about what recovery actually is and how recovery-oriented services operate differently than traditional services. Often related to lack of ongoing training opportunities for staff at all levels of the system. Regimentation of services and programs (due in part to funding requirements and regulations); extensive paperwork. Requirements limit time for service delivery and relationship building. Lack of trust between consumers and providers. Use of language that does not reflect hope, positive expectations or recovery.

Medical Model Orientation - Entrenchment in traditional medical model approaches and assumptions. Difficulties viewing mental illness as more than a biological phenomenon and reliance of medication as the primary treatment option; resistance to expanding the role of mental health services to address broader life and support issues of the people receiving services. Emphasis on primacy of medication as treatment. Narrowing the definition of recovery to “symptom management” and focusing change initiatives to over simplified, feel good strategies that may or may not be effective in achieving real transformation.

Lack of Basic Resources – Limited economic opportunities/jobs, housing, reliable transportation, opportunities for socializing in regular community settings.

Education & Training - Lack of education, training, and support for both consumers and mental health workers to do things differently. Little knowledge about how recovery happens, or about

rights. Few recovery mentors or role models for either consumers or mental health workers. Workers often do not know what do differently, especially in terms of relationships with consumers, assessment, service planning/review, conflict negotiation and crisis response. Competencies of recovery-oriented workers are not well articulated or integrated into formal training and professional development activities. Workers who do work differently – or want to – may lack support of their organizations or colleagues.

Regulatory/Organizational - Policies and regulations that limit flexibility and specific recovery practices. Overwhelming rules/policies/regulations and a rigidity that limits opportunities to change them. Counties focused on regulatory compliance, not creative approaches to achieving outcomes. Structural and philosophical divisions between OMHSAS and Department of Health (DOH), county administrators and single county authorities. Quality evaluation and licensure reviews that focus on structural components and standards compliance rather than personal outcomes and service effectiveness.

Funding – Inequitable funding across agencies. Focus on narrow definitions of “medical necessity” - on the needs of the body, and does not include the needs of the mind, emotions, or spirit. Reinforces the medical model orientation. Lack of flexibility or capacity for individualized treatment. Little funding for peer support resources statewide. Funding structures that pay for “more of the same” and have little capacity to leverage the flexibility needed to support a different array of services. Limited or no opportunity to consider a broader array of treatment approaches, including alternatives to traditional medical treatment.

Consumer & Family Involvement - Limited consumer and family involvement at all levels. Resistance to consumers and family members as full partners in planning, governance, training, and service delivery activities. Self-congratulations for tokenistic appointments or advisory groups with no power. Exclusion from education initiatives and lives of their family members. Mixed or dismissive messages about the importance of peer support options both as stand-alone services and within the umbrella of a more traditional agency. The language may be there, but the funding and technical support is not. Similarly there is frequently mixed response and comfort with employing people in recovery from mental health problems as staff in traditional agencies, despite growing research support that service outcomes may be enhanced through this practice.⁴

Addressing Challenges and Barriers

The first steps of transformational change are to develop a vision of the desired destination and to plot a roadmap for getting there. The roadmap must include not only the proposed route, but also an understanding of how the path may twist and turn and what roadblocks may be anticipated. Sometimes detours and “rest stops” are necessary. However, if there is a firm destination in mind and a commitment to getting there, roadblocks, detours, and rest stops do not derail the journey.

⁴ See for example, Felton et al., 1995; Solomon & Draine, 2001

The following challenges and barriers are highlighted as needing critical review, strategic planning and specific actions to enable the forward movement of transformation to a more recovery-oriented system in Pennsylvania. Developing supports and resources in addressing these core areas can create a strong foundation for future activities.

Power

The strong civil rights and empowerment roots of recovery in mental health have helped us understand that power cannot and should not stay concentrated in the hands of a few. The recent rise of interest and initiatives focusing on empowerment and self-determination are representative of the necessity to come to grips with the need to rebalance the traditional power structure within the mental healthcare system.

The mental healthcare system has considerable influence and power over the lives of the people it serves. Control of access to treatment resources and the kind of services received, determinations of capability and competence for decision-making, ability to use coercive mechanisms to enforce compliance to treatment requirements, living arrangements, lifestyles, creating and documenting personal lives and history through clinical records are only a few of the myriad ways the system holds power over the persons it serves. This power can be overt and obvious, but it is also often very covert and communicated through assumptions, language, and expectations.

One of the most fundamental challenges of systems transforming to a recovery orientation is to take an honest look at how power is held and communicated within the service system. One of the most important areas for providers to review is the assumption that the professional is the sole expert and “knows best”. This stance denigrates the knowledge and expertise that individuals have gained about their own lives and needs and de facto is actually diminishing and patronizing to the dignity of people.

However, shifting to a “consumer is always right” approach is equally dismissive of the knowledge, expertise, and resourcefulness of providers, which can contribute depth and breadth to a person’s understanding about his/her circumstances and options. This is the basis for considerable concern about risk and liability on the part of providers who believe they must manage risk by maintaining firm control over those they serve. If consumers are free to do anything they want, providers believe they will be left “holding the bag” when some of these decisions result in untoward consequences.

Both of these stances are limiting, polarizing and frequently non-productive since they often result in power struggles, resistance, reactance, reluctance and retaliation on the parts of both consumers and providers. Often consumers give up fighting for themselves and find it simpler to allow the system to take care of them and make decisions for them. Deegan refers to this phenomenon as “spirit breaking”.⁵ Spirit breaking is often mistaken for acceptance, compliance and satisfaction.

⁵ Deegan, P. (1990) Spirit Breaking: When The Helping Professions Hurt. *Humanistic Psychologist*. 18:3, 301-313.

In a recovery-oriented system the goal is to rebalance power so that the expertise and contributions of both the consumer and the provider are mutually respected and have bearing on decisions about treatment. In this “power with” orientation, the fiduciary responsibility of the worker to act in the best interest of the consumer remains intact, but the decision of what is in the best interest no longer rests entirely with the professional.

Consumers and family members are becoming more active partners in service design and delivery, demanding and exercising voice in what has been primarily professional domains. As the balance of power shifts, the nature of helping relationships becomes less prescriptive and more collaborative. Professionals are less likely to be entitled or empowered to make overarching treatment or lifestyle decisions that the staff person considers to be in the best interest of the client. While these changes may decrease the traditional power of the mental health professional, they may increase the mutual empowerment that allows shared goals to be accomplished.⁶

In a recovery-oriented service system, attention to person-centered/person-authored service planning, individual and collective voice in planning and policy-making, governance, administration, training, evaluation, and other aspects of the system are paramount. The adage “nothing about us without us” captures the fundamental importance of how power in the mental health system must be rebalanced.

Relationships

Closely related to the balance of power is the relationship between those who provide or administer services and those who need or use these services. As the balance of power is leveled, many questions emerge about roles and boundaries between providers and consumers. This is compounded when people who may have received services, or are currently receiving services from an organization, are engaged as workers or board members for that same organization. The traditional relationship rules that clearly demark the roles of “workers” and those of “clients” are confounded when the reality of the old adage “once a client always a client” is now “once a client, now a colleague”. Workers and consumers may both struggle with this uncharted territory and, when unresolved, these challenges can create harm and difficulty for all involved, potentially thwarting well-intended efforts.

This phenomenon is not limited to traditional organizations or services. One of the unique benefits of peer support and consumer-delivered services is that helping relationships are founded on the basis of shared experience and more equal status. The traditional professional/client roles are not entrenched. However, there are also many challenges in these relationships, which may include balancing employer expectations and organizational responsibilities with personal relationships and boundaries. Role strain is pervasive for many consumer professionals and peer support specialists.

There are a number of agencies and organizations who have developed successful approaches to addressing these concerns. Further, many professional guilds have been working to address these issues in updated versions of their codes of ethics and practice guidelines.

⁶ Curtis, L.C. & Diamond R. (1997). Power & Coercion in Mental Health Services. In Blackwell, B. (Ed.) (1997) *Treatment Compliance and the Therapeutic Alliance*. Toronto, Canada: Harwood Academic Publishers. 97-122.

Coordination and community

Community connection and coordination needs to be considered on two distinct levels. From a systemic or programmatic perspective, there is increasing need for coordinated and integrated services to be established within and across networks as well as across systems. The NFC Report repeatedly references the need for integrated treatment strategies, particularly in the areas of co-occurring substance abuse and lifespan screening. Schools, primary health care and criminal justice are specified as key areas for coordination.

There are a number of reasons for this emphasis on integrated, coordinated community-based care. The primary reason is to reduce the experience of fragmented, fractured, and conflicting care by consumers, their family members, as well as providers themselves. Secondly, it recognizes that mental health problems are not rare or relegated to a discrete subset of the population. They reach across cultures, ages, communities, genders, and so forth. Treatment is no longer isolated to psychiatric institutions or mental health facilities, but occurs in a range of community settings from McDonalds to the local housing authority apartment complexes and in the offices of primary care physicians. Treating mental health problems outside of the context of where and how people actually live is ineffective and often stigmatizing.

Maximizing use of public dollars means coordinating resources and care from a myriad of public and private services. Finally, for many environmental problems and stressors related to homes, jobs, physical health, and relationships factor into their mental health problems, either as causes or as exacerbations. To really treat mental illness effectively, often the environmental issues must be addressed concurrently.

From a more individual vantage point, it has been a common experience of people with serious mental illness to have their lives enveloped by services. This is so prevalent that some of the “resistance to treatment” that providers identify in the people they serve can be attributed to a fear of being “swallowed up” by services. Traditionally a good mental health system has been assessed by its comprehensiveness – the number and type of services provided: housing, work, treatment, socialization, health transportation, and so forth. Individuals receiving care and support had little contact with the community as citizens and little opportunity to build relationships with individuals not connected with mental health services. Services were substitutes for life. Further, the system encouraged individuals to become dependent on these services, which often had few clear paths leading to an exit. Systemically, this created a bottleneck with little flow-through and large demand waiting for access. Individually, this creates an environment whereby consumers become life-long clients and the expectation of “good clients” is compliance and maximal use of these services. People become institutionalized to their services in the community rather than an asylum on a hill. Further, fluctuating mental health budgets are a source of anxiety for consumers who worry whether the programs upon which they have become dependent will continue to be funded.

From a recovery vantage point, the role of the service system is to help individuals establish and sustain rewarding and meaningful personal lives. This may entail a wide range of services and supports – some of which may be offered by mental health programs, but many of which are available in other venues in the community: community colleges, local clubs and associations, businesses and landlords, neighbors, religious groups, and so forth. The role of mental health

services is no longer to be all things to all people, but to help individuals meet their personal needs through a wide array of community resources. Similarly, it is not the role of mental health workers to substitute for a friendship network for the people they serve. It IS their role to help individuals build a supportive network of friends and family members with whom they can have reciprocal and valued relationships.

Every mental health treatment plan should have clear references to how the program is helping the individual with community resource acquisition and the strengthening of his/her personal support networks. These are the things that build resiliency and help individuals manage life's ups and downs with minimal psychiatric impact. Mental health treatment and services are a means to an end; community, connection, and relationships are part of that end.

Peer Support and Consumer-Run Services

Peer support and consumer-run services are emerging as an important promising practice. A recent multi-year, multi-site study of consumer-run services sponsored by the Center for Mental Health Services (CMHS) found that consumer-operated peer support services are effective and increase well-being. Peer support can reduce symptoms, enlarge social networks and enhance quality of life, especially when offered in adjunct to traditional mental health services. Further, people who are offered consumer-operated peer-support services show greater improvement in well-being over time than those offered only traditional mental health services.⁷ In addition to NFC recommendations, research evidence is mounting that peer support and consumer-operated services must be a part of the service array available to persons with psychiatric disabilities.

It may be useful to clarify what is meant by peer services. Consumer-operated services differ from traditional mental health services in some basic ways that include the following characteristics:⁸

- Non-reliance on professionals. Participants in self-help programs take responsibility for planning and managing the group.
- Voluntary participation. Participants stay involved by personal choice, not by requirement or force, or as a way to continue receiving entitlements.
- Equality among participants. Participants, whether receiving services or providing them, are equal.
- A non-judgmental atmosphere. This promotes trust and mutual acceptance.
- Informality and avoidance of artificial barriers such as those between “patients” and “professionals.”

Further, a common set of values and philosophies typically guide consumer-operated services.⁹

⁷ Campbell, J., Lichtenstein, c., Teague, G., Banks, S., Sonnefeld, J., Johnsen, M., Zempolich, K. and the COSP Steering Committee. (2004). *Consumer-Operated Services Program (COSP) Multi-site Research Initiative: Overview and Preliminary Findings*. Presentation to Alternatives Conference, October 16, 2004.

⁸ Van Tosh L. and DelVeccio P. (2000). *Consumer/Survivor-Operated Self-Help Programs: A Technical Report*. U.S. Center for Mental Health Services.

⁹ Ibid.

- **Peer Support:** Opportunity for mutual and reciprocal caring among individuals who share common experiences.
- **Recovery:** The vision, principles, and practices that stimulate and support people with serious mental illness to “get better” and lead personally rewarding lives regardless of the presence or absence of psychiatric symptoms.
- **Hope:** A positive belief in a worthwhile future.
- **Empowerment:** Having control over one’s life and having capacity to impact things that affect one’s life.
- **Independence:** Stresses the importance of striving for self-reliance, self-governance, and the opportunity to function as productive citizens.
- **Responsibility:** Individuals must take personal responsibility for themselves, their decisions, and their actions, as well as their community.
- **Choice:** Opportunities to make informed decisions about treatment, services, housing, lifestyles, and things that matter in one’s life.
- **Respect and Dignity:** All individuals are valuable and have positive things to contribute. All individuals have civil as well as human rights that should be protected at all times.
- **Social Action:** Change comes to individuals and to systems when people take direct action to make desired changes occur.

These characteristics and values have been translated into a wide variety of consumer-run services including peer support, housing, crisis response and respite, benefits counseling, education, advocacy, evaluation and so forth.¹⁰ Further, examples of each type of these services can be found each in three different kinds of organizational structures: 1) free standing consumer-owned/operated non-profit organizations; 2) consumer-run programs under the auspice of another organization; and 3) peer support specialists hired into traditional agencies to provide these services.

Currently considerable work is being done to identify standards for peer support services¹¹ and to develop mechanisms for their eligibility for funding through Medicaid.¹²

¹⁰ Kendall, P. (in development). *Elements of Recovery*. Austin, TX: Texas Mental Health Consumers, Inc.

¹¹ Mead, S., & McNeil C. (2003). *Understanding What Useful Help Looks Like: The Standards of Peer Support*. Available online: akmhweb.org/Articles/PeerSupport.pdf.

¹² Curtis, L.C. (2002) *Current National Context of Consumer-Operated Services: Briefing Paper for the Texas Mental Health Consumers, Inc.* Austin, TX: TMHC.

Workforce Issues

“Without any infrastructure for recovery-based mental health care, it’s no wonder that so many administrators and clinicians have not bought into what is essentially a basic human right to feel better. In fact, just mentioning the word recovery seems to cause a stir, depending on your training, beliefs, and role in the mental health rehabilitation system.”¹³

Multiple evaluations and studies of services and programs show that worker attitude continues to be a significant barrier to personal recovery. Often these attitudes are openly stated, but as equally important, they are enmeshed into standards, policies, and practices. A 2004 study in Pennsylvania found that several key attitudes differentiated services with a stronger recovery-orientation from others.¹⁴ Less recovery-oriented services scored significantly higher on the prevalence of the following attitudes:

- Professionals are experts who know best.
- People will need help all their lives.
- There is an “us-them” feeling around here.

With the exception of a few programs or departments, the concepts of recovery are not integrated into the academic training and curriculum of most professionals working in the mental health field. Teaching recovery at an academic level is more than presenting philosophy and principles, it is also teaching recovery-based competencies as part of a core curriculum.

There is a need to establish recovery-based competencies, especially ones that “over-arch” specific professional guilds or roles. There is work going on in this area in several places in the U.S. as well as internationally.

Evaluation and Quality Assurance

You get what you measure. Traditional approaches to quality assurance focus on compliance to a set of standards, measurement against a predefined set of benchmarks, or satisfaction with services measures. Often quality assurance focuses on process measures such as contact hours, wait times, percentage of signed treatment plans, and compliance to standards rather than the actual impact of a service in the life of the individual person. Outcomes such as hospitalization rates, job placement, contact with criminal justice services, symptom management, attaining personal goals and so forth have also become increasingly important as measures of quality in mental health programs.

There are benefits and limitations to each of these approaches. For example, satisfaction surveys have become increasingly popular as quality tools in mental health. They ask, essentially, “Are you happy with what you are getting?” What if a person has never received anything else? Has no expectation or image of a service or life different than this? Has nothing else to choose from?

¹³ National Association of State Mental health Program Directors (NASMHPD)/National Technical Assistance Collaborative (NTAC), *e-Report on Recovery: Implementing Recovery-based Care: Tangible Guidance for SMHAs*. Fall, 2004. available online: <http://www.nasmhpd.org>

¹⁴ Curtis, L., Townsend, W., Hodge, M. (2004) *Becoming Recovery Focused: A Baseline Study of Six Mental Health Care Provider Agencies in Allegheny County, Pennsylvania*. Pittsburgh, PA: Allegheny Health Choices, Inc.

Alternatively, is worried that if he/she says he is not satisfied that something bad will happen – that he/she will lose services and/or that the program will lose funding and then he/she will lose the service. Often satisfaction is based solely on the limited range of what a person knows, and having nothing to compare it with, figures it is okay. The program gets information that all is well which can create a false sense of complacency and perpetuate a status quo.

With the current interest and emphasis on recovery, new questions are emerging about how to define and measure it in both individual and programmatic contexts. If recovery is a highly individual process, what are the outcomes? The benchmarks? Are there any consistent measurement points or parameters? How can programs be accountable to recovery approaches if they cannot be measured?

While recovery measurement is in a fledgling state at this time, there are a variety of tools and instruments in various stages of development that can help administrators, clinicians, peer providers, and consumers establish and assess recovery-based care.¹⁵ Presently, the Recovery Oriented System Indicator (ROSI) Measure is receiving considerable attention and undergoing broad scale piloting and validation and holds promise.¹⁶ As part of the recovery initiatives in the State of Wisconsin, the Recovery Oriented System Assessment (ROSA) was developed as an approach to assessing personal outcomes and to augment other quality assessment measures already in use by the behavioral healthcare system.¹⁷

One of the things that characterize recovery-oriented evaluation and quality assurance is the fundamental involvement of consumers and family members in the development of the instrument and evaluation methods, as well as evaluators themselves. Pennsylvania has solid experience in supporting consumers and family members as primary evaluators of the quality of services.

Medical Necessity & Evidence Based Practices

The concept of medical necessity drives both access and funding in most components of the behavioral healthcare system. Part of the challenge with this concept is not on the “necessity” but on the definition of “medical”. Pennsylvania has successfully, through the inception of the Pennsylvania HealthChoices Medicaid managed care program introduced a broad behavioral healthcare mandate to public services, including housing, respite, peer support, and fitness. This has helped to expand the range of resources, focus of services, and the definition of medical necessity. However, introducing recovery concepts as a driving principle in the system also raises the bar. It challenges service systems to grapple not only with assumptions about psychiatric disorder, chronicity, and healing but also with what it takes to truly help individuals build real lives and the role and limits of the system in this process.

¹⁵ NASMHPD/NTAC (2004). *E-report on Recovery, Fall, 2004*. Available online: www.nasmhpd.org. See for example, references for work by Ridgway, Onken, Curtis, Ralph, and others.

¹⁶ Onken, S.J., Dumont, J.M., P. Ridgway, P., Dorman, D.H., Ralph, R.O. *Update on the Recovery Oriented System Indicators (ROSI) Measure: Consumer Survey and Administrative-Data Profile. Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators*. Washington, DC: Joint National conference on Mental Health Block Grant and Mental Health Statistics, June 1-4, 2004.

¹⁷ Curtis, L.C. & Mental Health Quality Improvement Project Team of the Wisconsin Bureau of Mental Health and Substance Abuse Services. (2005) *Recovery Oriented System Assessment (ROSA)*. Madison, WI: Wisconsin Department of Health and Family Services, Division of Supportive Living, Bureau of Community Mental Health and Substance Abuse Services.

At one point there was understanding that the body was one element of medicine, equal to the mind and the spirit. Huge advances in science, technology and pharmacology in the last half of the twentieth century have resulted in a narrowing of this focus and placed emphasis on those aspects of “medical” that a pill can fix or a device can measure.

More recently some branches of medicine have returned to the importance of healing and the recognition that for a person to heal from a disease or disorder often takes more than pills and machines. People become unwell – and well again – in an environmental and social context. These factors are hugely influential on biological aspects of human functioning. Medications are an important part of the picture for many people, whether they are for treating diabetes, asthma, cancer, or mental illness. However, unless environmental and often the social and spiritual factors are also incorporated into a treatment or support, there is no healing.

It does not make sense to prescribe things that are not needed to help a person heal. Yet this is commonly done when we “prescribe” that a person have hours of day treatment or participate in endless, often redundant groups. It does make sense to work with each individual to identify the kinds of things that that person believes may help them heal. This is medical necessity. The skill of the provider includes helping to bring an individual to the understanding that change is both needed and do-able in their lives, that there are a range of avenues for achieving changes, for helping individuals make informed choices about their personal care and developing ways of assessing the effectiveness of that treatment against their own standards of success. In order to shift to a more recovery-oriented system of care, a broader definition of “medical necessity” needs to be considered.

Evidence based practices are similar. Certainly it does not make sense to provide services that do not work. Using a body of research findings is one important way of determining what works and what doesn’t work. Some of the practices promoted as evidence-based do have a considerable body of research to substantiate their effectiveness in achieving certain desirable outcomes. However, psychiatric services have traditionally not been well researched, nor have research funds been available to investigate a wide range of approaches to services. Further, many of the outcomes assessed in psychiatric service research have been determined by the researchers, funders, and pharmaceutical firms, and have not been informed by the practical or lived experience of individuals who have been diagnosed with psychiatric disorders. Good, effective, and cost efficient mental health care is in the interest of everyone. Caution must be exercised, however, to ensure that the definition of “evidence” and the parameters of “evidence based practices” are broad enough to encompass the needs of individuals actually using the services.

Research and assessment of quality should not be relegated to only academics or special-interest funders. Part of the transformation to recovery-oriented care is the need to instill the values of self-reflection, ongoing program evaluation, and a desire to continually improve how behavioral healthcare services help individuals with their personal recovery. This entails seeking out new information from many arenas, including academic studies, and using this information to improve the quality of care for the person’s services. However, it also means that every program should be accountable to its own internal and external evaluations and to look forward to findings that will help them help people in their process of recovery.

Financing

In an era when level-funding feels like a success, when need and demand far outstrips the available resources, when social and human services are devalued politically, when we are constantly asked to do more and with less, discussing financing is difficult. However, you get what you pay for. Hence financing must be considered. Many services are underfunded and providers work very hard to make their resources stretch to cover all the needs of the individuals they serve.

In addition to ensuring an adequate foundation for basic care, several innovative approaches to financing are in consideration by various mental health authorities. These include:

- Efforts to capitate and manage funding through health networks such as HealthChoices. Used well, this approach can allow for more flexibility than traditional fee-for-service funding approaches. Emphasis in many of these managed care services is on accountability for outcomes rather than prescription of a specific set of required services. In Pennsylvania, HealthChoices shows promise as a vehicle for increasing flexible funding at the local level and should be expanded to all regions of the State.
- Separate funding streams for clinical and “recovery” service bundles. In New Hampshire, clinical services include basic treatment, inpatient care, psychiatric services and so forth. Another cluster of services, termed a “recovery bundle” are funded through the Medicaid Rehabilitation Option. Services, which are reimbursable in this structure, include education and vocational services, recreation and community involvement, alternative treatments, peer services and some individual recovery programs. These services are considered “non-medical” in that they do not require supervision by a physician, but they continue to require outcome accountability.
- Another area receiving some attention is the development of Individual Recovery Accounts, which allow individuals to directly purchase their needed services. In this approach, the service is primarily accountable to the person purchasing the service – in this case the individual, rather than a mental health authority. Called Self-Directed Care this approach has been used in some disability services and is being piloted in a few mental health settings.
- Related to Self-Directed Care is the limited use of Personal Assistance Services/ Personal Care Services available through Medicaid funding or in some areas home and community based waiver. Again, this is a model that has been successfully used in physical and developmental disability services and may be appropriate for consideration in psychiatric disability as well.

Recovery Dialogues between Mental Health and Substance Abuse Services

A Call for Change is a first step for mental health services to begin the transformation toward more recovery-oriented services. However, mental health services must move ahead only in concert with other services, including Substance Abuse Services.

It is *critical* that mental health and substance abuse services begin dialogs to respectfully explore their shared and diverse understandings about the concept and process of recovery. The goal of these dialogues is enhanced understanding and the development of a consensus statement on recovery. Mental health and substance abuse services need to conjointly develop and author any future iterations of *A Call for Change* and be collaborative parties to all strategic planning initiatives.

Recovery Education

Recovery education needs to be ongoing and instituted as part of every academic curriculum for professional training. A set of competencies for recovery-oriented staff needs to be established to help guide training. Ongoing recovery education needs to be required as part of the continuing education requirements for all licensure groups. Training needs to include “the basics”, but also more in-depth attention to implementing recovery-focused treatment and support, including risk management and crisis prevention.

Recovery education for consumers needs to be made available and promoted in every region on a quarterly or semi-annual basis. There needs to be a process for training consumers to provide recovery education to other consumers.

Ongoing training must be provided for supervisors on how to mentor and help staff address day-to-day service planning and treatment/support activities from a recovery stance. Consumers need to be involved in curriculum development as well as training delivery. Staff should not be expected to work from a recovery-stance without the support within their organizations.

Review of Licensing, Regulations & Policy

A policy review needs to be implemented and priority areas for change identified. The review should include “ground up” evaluations about the kinds of policy barriers that hinder recovery-based care and that may need to be addressed as priorities. Establish a toolkit for recovery outcome evaluation and shift toward outcome accountability as primary element of satisfaction and funding.

Toward Transformation

Transformation: (noun): from the Latin roots to change TRANS (across) and FORMA (shape). 1: a change in form, appearance, nature, or character. 2: the process of doing so. This transformation must ensure that mental health services and supports actively facilitate recovery and build resilience to face life's challenges.¹

Transformation is ultimately about new values, new attitudes, and new beliefs; it is about how these changes are expressed in the behavior of people and institutions.²

No one can 'transform' someone else...each must do their own work. Hope and supports are essential.³



Only a Beginning

The New Freedom Commission described transformation as a vision, a process, and an outcome. However, as recognized by members of the Commission: “Transformation was not achieved by the Commission; it depends on action that we and others will advance.” Therefore, to, *A Call for Change* recognizes in its charge that transformation in Pennsylvania will depend not only on the actions of OMHSAS, but of all stakeholders.

A Call for Change simply offers an image of the destination – a vision – and provides some ideas for moving forward the process of transforming the Pennsylvania behavioral healthcare system toward more recovery-oriented policies and practices. It presents some of the critical features of a recovery-oriented mental healthcare system and offers guidance from many sources including invested stakeholders in Pennsylvania, the new federal mandates, and the experience of other states and regions undertaking transformation.

It is expected that there will be a diverse response to this document and the call for change in Pennsylvania. It will take time for the ideas to be understood, debated, and ultimately embraced and made real in Pennsylvania’s mental health service system for adults. Throughout this process, there will be unwavering commitment by OMHSAS that recovery is the overarching theme that

¹ New Freedom Commission *Final Report 2003*.

² A. Kathryn Power, Director, Center for Mental Health Services, SAMHSA. *Transforming Mental Health Care in America*. Presentation to the National Advisory Council, June 14, 2004.

³ Ed Knight, cited by Michael Hogan in *Transformation: ACMHA, The President's Commission, And the Change that we Seek*. Available at http://www.acmha.org/Hogan_ACMHA_Santa_Fe_05.ppt

will guide all state-level planning and policies. In itself this will help to build consensus among stakeholders and sustain momentum for change.⁴

Next Steps

Based on input from various stakeholders in Pennsylvania and the experience of some other systems that are tackling transformation to a more recovery-oriented approach, there are some overarching steps that must occur in order to move forward *A Call for Change*.

Review, Consensus & Commitment

There must be a degree of consensus and commitment to the vision and concepts outlined in this document before it can be used as a guide for transformation. This will entail ensuring that there is an adequate process for review. A diverse response is to be expected, but for *A Call for Change* to serve in guiding change, leaders from stakeholder groups and policy makers at the State level must have a shared commitment. . This process will require compromise.

Gaining commitment will entail ensuring an adequate dissemination, review, and dialogue/discussion and revision process. This process will occur over time and not according to a planner's timeline. It must be remembered that one of the objectives of *A Call for Change* is to encourage discussion and to function as a lightning rod for change initiatives.

Training & Technical Assistance

The assumption cannot be made that there is widespread knowledge and acceptance of recovery principles in the field. Ongoing technical assistance and education are crucial. Information needs to be collated into a format and disseminated in a way that is accessible, digestible, and useable to the field.

3-5 Year Implementation Plan

A strategic implementation plan needs to be developed for the next 3-5 years. However, it is not expected that transformation will be complete in 3-5 years and it is expected that others will follow the first plan. The focus of the first implementation plan should be on what it will take to establish a solid foundation and initial stages of change. There is no single approach to implementing recovery-oriented care or transforming the mental healthcare system. The plan should focus on what is concrete and do-able in this time period rather than on broad philosophical shifts. This strategic plan should be a core element of meeting the expected federal requirements for comprehensive state-level mental healthcare planning. It should be approved, disseminated, and used for actual service development and financing decisions

Annual Progress Reports on Implementation

Progress reports on implementation should be made available on at least an annual basis. "You get what you measure". It is important to establish a mechanism whereby the field can receive information about the status of the transformation and implementation of various initiatives.

⁴ Anthony, W.A. (2004). Overcoming Obstacles to a Recovery-Oriented System: the Necessity for State-Level Leadership. NASMHPD/NTAC e-Report on Recovery, Fall, 2004.. Available online: www.nasmhpd.org

OMHSAS can model the principle of continual and reflective learning by ensuring that the field receives regular updates in addition to requesting implementation and evaluation updates from the field. In system change as well as in facilitating change in the management and clinical arenas, it is always a good policy to “catch’em doing it right” and to celebrate progress toward a desired end, even if that progress is slower.

Your Call to Change

The Pennsylvania transformation will depend on the action of not only OMHSAS, but of all stakeholders. A successful transformation depends not only on state level policymaking, but on a commitment to change that is demonstrated by many actions, large and small, that we as individuals and vested groups take.

There must be a degree of consensus and commitment to the vision and concepts outlined in *A Call for Change* before it can be used as a guide for transformation. This cannot happen before the document is disseminated, reviewed, discussed and debated. Listed below are a few ways you can begin the process in your agency or area.

Promote Discussion and Dialogue

One of the objectives of *A Call for Change* is to encourage discussion and to function as a lightning rod for change initiatives. The concepts and ideas presented herein are not unanimously accepted or even understood. Share *A Call for Change* with others. Ask colleagues, staff, consumers, family members, and people from other agencies to read it. Get extra copies and share them generously.

Disseminate the document.

Create opportunities for regular and ongoing discussion and dialogue. What can *we* do? Here? Now?

Ensure that consumers and their families are active participants in dialogue. Involve many points of view.

Keep focused on positive change – if these ideas don’t seem right for your area, how would/could you promote change and transformation toward recovery-oriented services in your area?

Build commitment to making fundamental changes in your services.

Keep dialogues active throughout the process.

Identify Leaders

What individuals and entities can be leaders for change in your area? You may want to create a group of diverse stakeholders to be the nexus of local change initiatives. Use *A Call for Change* to help educate potential leaders, as well as to serve as a focal point to bring current leaders to the table.

Self-Check

The indicators of a recovery-oriented service system provide a broad array of ways agencies and counties can begin transformation initiatives at the local level. Use these indicators to begin discussion and self-assessment initiatives. Consumers and family members should be partners in all discussions and involved in all assessment activities. Your areas of strength should be

recognized and celebrated. Areas for development should be prioritized for transformation initiatives.

Be Honest

It is one thing to tweak the edges of a service or make some cursory changes in a program. However, as the NFC reminds us, “Transformation is more than mere reform; it is about changing the fundamental form and function of the service system.”⁵ What worries you about this direction? What attitudes, assumptions, and fears keep you from moving forward? How can you identify and openly address these assumptions in a positive and productive way in your area? Will you personally commit to being a positive force for change, helping Pennsylvania to transform its public mental health service system to better support individual recovery?

Visioning

By the end of 2006 all mental healthcare organizations in the state, including counties should have vision and mission statements that embrace recovery. Review your mission and vision statements. What do they say about the values or assumptions we hold? About how we see ourselves and our purpose? Do they reflect persons or programs? Outcomes or services? Is our mission squarely on helping individuals with their individual journey of recovery? Use the discussions stimulated by *A Call for Change* to help inform this process.

Identify Specific Problems and Challenges

What are your specific areas of challenge – including attitude, training, personnel, regulatory, financing, contracting and so forth? It is understood that there are pressures within the system at all levels to maintain the status quo. For transformation in Pennsylvania to occur, we all need to become very clear and very specific about the kinds of contracting, financing, training, and regulatory changes that are needed. Document and share very specific examples of how a barrier impedes efforts to provide more recovery-oriented services as well as your ideas about how those challenges might be addressed.

Forge New Partnerships

Reach out – look beyond the mental health arena. With whom can you partner and how can you work together to support people’s recovery?

Make a Commitment and Take Action

What goals and actions are needed on your part or in your local area to move the spirit of this document forward? What actions are you willing to commit to taking? What are some of the things you can do *now* to shift toward a more recovery-oriented approach? What might be some of the things that you could tackle in the next year or so? What kinds of groundwork could you lay in the short term for longer-term changes.

⁵ Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Service (2005). *Transforming Mental Health Care in America. Federal Action Agenda: First Steps*. DHHS Pub. No. SMA-05-4060. Rockville, MD.

Boiling it Down

Many of the above actions boil down to four key questions. Generating your own answers to these key questions will take you a long way toward meaningful transformation of the public mental health system for adults in Pennsylvania.

How can you use this document?

How will you use this document?

How can we partner to support people's recovery?

What is your constituency willing to take responsibility for?

Conclusion

A Call for Change: Toward a Recovery Oriented Mental Health Service System for Adults is a significant step in the transformation toward more recovery-oriented services in Pennsylvania. It outlines the diverse roots of recovery in mental health, collates current knowledge and ideas from within the state and other contemporary sources about what recovery looks like at the individual, programmatic and systemic levels, and offers some suggestions for strategic next steps toward transformation. Its purpose is to generate discussion. It is only through discussion and dialogue that greater awareness and consensus can emerge.

Some of the key themes and lessons that have been learned over the centuries of reform in Pennsylvania include the following. They apply equally today.

- People with mental illnesses can and do get better with humane and individualized services, opportunity, and dignity.
- Innovation and leadership come when the focus is squarely on providing better and more effective services to those who are served by the system.
- There are dedicated people in Pennsylvania working independently and in groups, with good ideas born of their passion to help people labeled with serious mental illnesses to live rich and rewarding lives -- and with the tenacity to find ways to achieve this goal despite barriers and obstacles.
- All change and innovation requires risk-taking. Leaders see the need for change and help the system take necessary risks.
- What seemed risky a decade or two ago, is now commonplace.
- There is danger in complacency and apathy.

It is easy for systems under pressure to lose sight of individuals and their needs and for workers to lose sight of their purpose, passion, and willingness to take some risks. We default to management of groups, populations, and covered lives rather than helping people to heal. A narrow reliance on only known, tried, or standardized (albeit often ineffective) ways of doing things results in an unyielding perpetuation of the status quo. When service systems lose heart, they also lose effectiveness, satisfaction, and opportunity.