

**The Recovery Concept:
Implementation in the
Mental Health System**



**A Report by the Community Support
Program Advisory Committee**

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Table of Contents

Community Support Advisory Committee Members	2
Acknowledgments.....	2
Preface.....	6
Background	7
Ohio Dialogues	9
Recovery Themes.....	10
• Jobs	10
• Power and Control (Empowerment)	11
• Stigma	12
• Peer Support.....	13
• Family Support.....	15
• Community Involvement	16
• Access to Resources.....	18
• Education	19
• Clinical Roles and Relationships	19
Summation	22
References	22

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to the consumer and family leaders of Ohio who have given their time to develop the recommendations and whose continued work, support, dedication and commitment to make the mental health system in Ohio the best that it can be with and for mental health consumers in Ohio.

In addition, the committee would like to thank Sam Hibbs for his excellent work on the layout of this document.

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Community Support Program Advisory Committee to the Ohio Department of Mental Health

July 31, 1995

Michael F. Hogan, Ph.D. Director
Ohio Department of Mental Health
30 East Broad Street
Columbus, OH 43215

Dear Director Hogan:

As the President of the C.S.P. Advisory Committee, a mental health clinician, and consumer of mental health services in the state of Ohio since 1966, the Recovery Concept is one of the most sensitive and endearing of any possible endeavor for me personally. Without the dedication, compassion, and love from my former therapists, psychiatric nurses, and community support staff, I would not been able to reassemble my life and enjoy the balance and "recovery" that I am blessed with today.

My purpose in writing to you today is to offer, for you consideration, the C.S.P. subcommittee report on *The Recovery Concept: Implementation in the Mental Health System*. As a community support committee, we take our work as advocates for the well being of mentally ill consumers in our state very seriously. We are particularly excited about the recovery process and its potential impact on service development, delivery, and outcomes.

The committee members who contributed to this report come from the three basic components of mental health: clinician, consumer and family member. As you read through their detailed and comprehensive account, savor the expert approach with which they tackled the difficult nuances of the recovery concept. Digest the detailed process as they review the history of recovery-what it was and what it can be. And finally, look with a discerning and educated eye at how the Department of Mental Health and local community mental health systems could profit from the hard work of these caring and devoted committee members. I'm certain you will see the fruits of their labor.

Thank you for your consideration of this report, for your commitment to recovery, and the personal attention you have given to our committee.

Sincerely,


Michael Gulvas, L.S.W., Chairman
Community Support Program Advisory Committee



Ohio Department of Mental Health

30 East Broad Street
Columbus, Ohio 43266-0414

July 31, 1995

Community Support Program Advisory Committee:

I take great pride in knowing that the mental health system in Ohio is embracing the concept of recovery. I have seen this movement develop to a point of light at which clinicians understand that people with mental illness—far from behaving like passive “patients”—work hard at and are very skilled in living with and managing their disorders.

The recovery phenomenon can best be described through the voices of those living the experience as Esso Leete says,

“There is no doubt that presence of major mental illness can shatter lives, yet it is important for professionals, family members, and us as clients to realize that there are steps we can take to minimize the effects of a mental illness and to live productively. As we encounter the inevitable daily hassles, we must deal with them constantly and creatively. This process can be part of a learning experience, an opportunity to make sense out of our world and our relationships. Recognizing and building on our assets, our strengths, is the most important step we can take on our road to recovery. And one of our most powerful strengths is our ability to develop coping mechanisms for dealing with our disorder.”

The Community Support Program Advisory Committee has done an excellent job in documenting the recovery movement in Ohio. The information describes what consumers say in helpful to them as they negotiate their recovery. This document will serve as a educational tool on the concept of recovery for professionals, families and consumers themselves. As the system moves toward manage care, it is imperative that professionals and consumers work in partnership to assist consumers. The mental health system should utilize the recommendations reported by the CSP Advisory Committee to develop a recovery model of treatment for all consumers in the system.

This report can be used as part of a strategic step to move the entire system to a recovery model. It goes beyond a few consumer controlled “alternatives, a few consumers and family members on boards, and business as usual for everyone else. In a recovery oriented system, every admission to a hospital, for example, would be used as an opportunity for change, not as a crisis to be weathered. We would move beyond “maintenance” treatment to actively working to help people control their lives. Instead of giving a few consumers power by appointing them to boards and councils, we would empower every consumer to control their own life. We would listen more to what people want, and a little less to what we think they need.

History says that individual people are far more able to heal themselves than the mental health system is. The following is the challenge and prediction that a consumer leader has provided.

The mental health system will not change until it absolutely has to, and thankfully, that time has finally come. No longer do mental health clients feel powerless: forced into treatment, coerced into power struggles, and administered therapy that others have determined to be in our best interest. We are changing the image of who we are and who we can become.

(Leete, 1992)

The Community Support Advisory Committee has developed for Ohio via this report a way in which the system can meet this challenge.

This Committee is to be commended for their work and accomplishments.

Sincerely,

Michael F. Hogan, Ph.D.
Director

Preface

The past thirty years have seen a very significant change in the way that severely mentally ill people (consumers) have been perceived and therefore how they have been provided services. Before the 1960s, all people with severe mental illness were viewed as being totally dependent on a system of care and the institution was seen as the sum total of treatment. Even with the development of new medications and treatment programs, deinstitutionalization in the last thirty years still does not satisfy all of the needs of the persons with severe mental illness now found in community settings. It has become obvious that consumers have many unmet social, vocational, educational and housing needs (Anthony, 1993). It is equally obvious that the community at large will be the milieu in which services will be provided to most of those with severe mental illness.

How to provide services was systematically approached in the mid 1970's when the National Institute of Mental Health defined the Community Support System (CSS) as "a network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community."

The Ohio Department of Mental Health (ODMH) Community Support Program (CSP) Advisory Committee philosophy (1991) states that, "people with severe and persistent mental illness have the right to live in the community and participate in a lifestyle of their choice. The philosophy statement further says, "It is the belief of the CSP Advisory Committee that a comprehensive program utilizing state of the art psychiatric, vocational, housing, nursing and social services tailored to individual needs will benefit all persons with severe mental disability and, moreover, may result in complete recovery for a substantial proportion of previously determined 'hopeless cases.'"

The CSP concept identified the essential components needed by a community to provide adequate services and support to persons who are psychiatrically disabled. (Anthony, 1993, p. 12.) These components include: mental health treatment, crisis response services, case management, health and dental care, housing, income support and entitlement, peer support and entitlement, peer support, family and community support, rehabilitation services, protection and advocacy, and self help (Anthony, Cohen & Farcus, 1990).

These essential components need to be utilized in accordance with the following principles adopted by the ODMH, CSP Advisory Committee (Membership Handbook, 1991). Services should: be consumer centered, empower clients, be racially and culturally appropriate, be flexible, focus on strengths, be normalized and incorporate natural supports and the service system should be accountable.

It is also necessary to combine the CSS concept with the rehabilitation model (Anthony, et al., 1990). Part of the rationale for the rehabilitation model is that severe psychiatric illness involves more than the illness or impairments manifested by hallucinations, mania, delusions, or depression. These impairments can be treated medically, but the person may suffer further

consequences of the illness described by Anthony (1993) as dysfunction, disability and disadvantage. Examples of dysfunction for those with severe mental illness include lack of work and social skills. Disabilities include unemployment and homelessness. Discrimination and poverty are examples of disadvantages experienced.

- The primary focus of psychiatric rehabilitation is to improve the competencies rather than simply alleviating symptoms and pathology.
- Rehabilitation tries to help the person adjust and adapt to specific environmental requirements.
- Psychiatric rehabilitation uses any and all techniques that are effective.
- Improving vocational outcomes for persons with severe mental illness is a primary focus of rehabilitation.
- An essential ingredient of psychiatric rehabilitation is hope.
- A client can increase in independence when accommodations are made.
- Consumers need to be actively involved in their rehabilitation plan.
- The two fundamental psychiatric interventions are the development of client skills and the development of environmental supports.
- Consumers will often need long-term drug treatment, but it is rarely sufficient by itself.

The Recovery Process: Background

The emerging concept of recovery from mental illness arises from the conceptual foundations laid by these models of a comprehensive community support system and the rehabilitation model. In particular, the change in focus from a treatment of symptoms to one of improving competencies leads directly to a recovery approach.

Recovery from severe mental illness has become a central issue over the past decade, growing out of the writings of consumers (Anthony, 1993). Most longitudinal outcome studies indicate that a significant number of people with severe mental illness are able to lead normal lives (Harding, Brooks, Tahamaru, Strauss & Bar, 1987a, 1987b; Harding, et al. 1987; Lin & Kleinman, 1988; McGlashan, 1988). How to facilitate such recovery is being widely explored.

Families who successfully cope with a chronic illness have been found to create a “normalization story,” usually at variance with the view of society and mental health professionals. While this emphasis on the abilities of the individual rather than the deficits seems to promote recovery, these families find that health professionals often disrupt the normalization process by

continually introducing a problem saturated perspective,” which “services the illness” rather than providing “the help one needs for getting on with your life” (Sullivan, 1994).

Sullivan (1994) calls for “a broad definition of recovery, one that not only focuses on the management of the illness, but also highlights the consumers’ performance of instrumental role functions and notions of empowerment and self-directedness.”

Anthony describes recovery as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (Anthony, 1993).

Hatfield and Lefley endorse a readaptation definition of recovery. “Recovery in a major mental illness does not usually mean ‘cure’ or return to the premorbid state. Rather, it means a kind of readaptation to the illness that allows life to go forward in a meaningful way. The adaptive response is not an end state, it is a process in which the person is continually trying to maximize the fit between his or her needs and the environment” (Hatfield & Lefley, 1993, p. 184). According to Hatfield and Lefley (1993), recovery requires acceptance of the illness, a sense of responsibility or control over one’s life, hope, and the support of others in addition to treatment and rehabilitation programs which emphasize cooperation with professionals and mutual support by consumers.

Medications have allowed many with severe mental illness to recover form the major impairments of mental illness, yet there is much more that consumers need to recover from. Not only must they cope with the lingering and/or recurrent symptoms, but they also seek recovery from the stigma that society places on mental illness, lack of employment opportunities and being tied to entitlement programs that restrict most economic choices and limit control over one’s own life.

Anthony (1993, pp. 18-20) lists the following assumptions about recovery:

- **Recovery can occur without professional intervention.** The task of professionals is to facilitate recovery; the task of consumers is to recover. Recovery may be facilitated by the consumers natural support system. ... Self help groups, families and friends are the best examples. ... Also essential to recovery are non-mental health activities and organizations, e.g., sports, clubs, adult education and churches...
- **A common denominator of recovery is the presence of people who believe in *and stand by the person in need of recovery*,** a person or persons in whom one can trust to “be there” in times of need.
- **A recovery vision is not a function of one’s theory about the causes of mental illness.** Recovery may occur whether one views the illness as biological or not.

- **Recovery can occur even though symptoms reoccur.** The episodic nature of severe mental illness does not prevent recovery.
- **Recovery changes the frequency and duration of symptoms.** As one recovers, the symptom frequency and duration appear to have been changed for the better. That is, symptoms interfere with functioning less often, and for briefer periods of time ... and return to previous function occurs more quickly after exacerbation.
- **Recovery does not feel like a linear process.** Recovery involves growth and setbacks, periods of rapid change and little change ... The recovery process feels anything but systematic and planned.
- **Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself.** Issues of dysfunction, disability, and disadvantage are often more difficult than impairment issues. An inability to perform valued tasks and roles, and the resultant loss of self esteem, are significant barriers to recovery. ... These disadvantages include loss of rights and equal opportunities, and discrimination in employment and housing, as well as barriers created by the system's attempts at helping. e.g., lack of opportunities for self determination, disempowering treatment practices. These can combine to limit a person's recovery even though one has become predominantly asymptomatic.
- **Recovery from mental illness does not mean that one was not really mentally ill.** People who have recovered or are recovering from mental illness are sources of knowledge about the recovery process and how people can be helpful to those who are recovering."

The Recovery Process: Ohio Dialogues

In April, 1994, ODMH and the Center for Mental Health Services sponsored a National Forum on Recovery for Persons with Severe Mental Illness. Mental health professionals, consumers, and family members were invited to present papers on recovery from widely divergent perspectives. Though the ensuing discussions were not intended to provide a consensus, there seemed to be general agreement that recovery is an internal, ongoing process requiring adaptation and coping skills, promoted by social supports, empowerment and some form of spirituality or philosophy that gives hope and meaning to life. The need for further research on recovery was expressed but the need for immediate steps to facilitate recovery was also recognized.

With this vision in mind, the Ohio Department of Mental Health began recovery dialogues across Ohio involving consumers, family members, and the CSP Advisory Committee to find out what meaning recovery had for people in this state.

Mental health consumers felt that recovery was a deeply personal experience and an ongoing process. Recovery, they said, involves hope and courage and is accomplished one step at a time according to individual abilities and goals. Consumers and family members also viewed making small improvements in functioning as a part of recovery, contrary to the expectations sometimes expressed by providers.

While this was a broad consensus definition of recovery, eight major themes also emerged:

- (1) Meaningful employment positively impacts the recovery process;
- (2) The stigma associated with having a serious mental illness continues to be one of the major barriers to the recovery process;
- (3) Positive human relationships can lay the foundation for recovery;
- (4) Consumers have the desire to develop positive, collaborative relationships with psychiatrists and service providers to improve treatment and service delivery;
- (5) Peer support is a definite aid to recovery;
- (6) Consumers want more control over their lives;
- (7) Education contributes to one's recovery; and,
- (8) Having access to needed resources improves the likelihood of recovery.

Recovery Themes

The following recommendations to enhance the recovery process for consumers are based on the expressed needs and concerns are based on the expressed needs and concerns of consumers and family members who attended the forums around the state, and the suggestions of the CSP Advisory Committee.

Jobs

Less than 15% of persons in the State of Ohio with a history of severe mental illness are employed. This percentage is less than that of any other disabled population. Employment provides consumers with both economic and psychological benefits. By returning to work, consumers are able to become more economically self-sufficient. As important as the economic advantage, is the increase in consumer's self esteem and community status. But jobs for consumers must include more opportunities than entry-level custodial or fast food positions in order to meet the needs of those consumers with abilities exceeding the demands of these jobs.

Recommendations:

- Prevocational and vocational activities and skills training should be available to all consumers.
- Job development and placement should be based on the expressed need and demonstrated interest of the consumers, rather than on the availability of any given job or training program. This is referred to as the “choose-find-keep” model of job placement.
- ODMH should actively encourage more jobs in the mental health field for consumers, setting the example for communities in the state.
- ODMH and local boards should support programs such as AMI of Ohio’s “New Vistas”, VISTA program which provides jobs and training to consumers and does not interfere with any benefits consumers are entitled to receive.
- ODMH and local boards should expand support for consumer-run services and/or businesses.

Power and Control (Empowerment)

It is very important for a person to make decisions about his/her life. In the past, almost all decisions were made for consumers. Thirty years ago when many people with mental illnesses were warehoused in institutions, it was most common for the hospital staff to make almost all decisions for the people in their care. For the persons with mental illness, control remained external to them (external locus of control). It is not healthy for a person to have little or no control over his/her life. This teaches overdependence on other and denies the possibility of recovery. Whether or not the controller has the consumer’s best interest at heart, this is a disempowering situation if continued without change or hope of change. The consumer learns to be helpless, needing and depending upon others to make decisions and accept responsibility.

It is important for the mental health system to become more responsive to consumers’ need for empowerment and the personal goals set by the individuals themselves. This can be accomplished in part by encouraging consumers to become self-sufficient, productive members of society.

Recommendations:

- Educate consumers about their diagnosis, prognosis, medications, and treatment.
- Involve consumers in the writing of treatment plans.
- Set up training programs to teach consumers how to work with the local mental health board.

- Have a person who knows how to work with the mental health system teach mental health consumers.
- Increase the number of consumers who are members of the mental health boards and require that vacancies be filled within six months.
- Consumers should play a key role in the development, implementation, and evaluation of all services. There should be an office of consumer affairs at every mental health board.
- Encourage hospitals and mental health boards to contract with consumer groups to participate in the evaluation of services. Consumer driven quality assurance must be established.
- ODMH should solicit input of consumers into the credentialing process.
- Consumer groups need to identify outcomes that board areas are mandated to implement through philosophy, oversight and funding.
- Consumers should have input into university curricula relating to mental health course work and aid in the training of mental health personnel.
- Train consumers to become more politically active and more involved in self advocacy.
- Have consumers provide assistance to hospital programs.
- Provide a workable advanced directive so that consumers can make decisions regarding their own future treatment.
- Insure that day treatment programs promote increasing independence rather than learned dependence.
- See also, *Clinical Roles and Relationships*

Stigma

The stigma associated with mental illness does much to hinder the process of recovery. Our language contains a number of words and expressions that are closely associated in a negative way with persons who have experienced mental illness. The list includes (but is not restricted to) mad, crazy, psycho, loony, and nuts. Misuse of words such as schizophrenic also contributes greatly to the stigma. Persons with a history of mental illness are very sensitive to this language and often internalize these stereotyping, negative, derogatory and degrading statements. Such usage is not only “politically incorrect” and insensitive, it is blatantly incorrect terminology and contributes to misinformation about mental illness.

The language and its misrepresentation of mental illness, creates a stigma that permeates our society. It can cause people with mental illness to devalue themselves and develop a poor self-concept. The media's portrayal of those with savagely violent behavior as being mentally ill presents a very, distorted view of those with a history of mental illness.

It is the belief of the CSP that stigma can be reduced with a proper and aggressive education/information campaign. ODMH working actively with consumers, family members and professionals should develop and implement a comprehensive anti-stigma campaign concerning mental illness. This program could take many forms, but it should be predicated on the belief that the more a person understands what a mental illness is, the more likely it is that they will treat consumers with respect and compassion. It would also promote early treatment and support of mental health programs.

The goal is "to challenge the negative attitudes and lack of sensitivity of the public toward people who are psychiatrically labeled. These attitudes often lead to politics that stigmatize and limit the exercising of basic legal, civil, and constitutional rights." (From the National Association of Psychiatric Survivors', "Goals and Philosophy Statement.")

Recommendations:

- There should be education regarding mental illness and the mentally ill at all levels of the mental health system.
- Mechanisms must be developed to combat stigma within the mental health system itself.
- ODMH should fund at least on anti-stigma public relations campaign designed by consumers. The person who presents the message should be a high profile, well respected person from Ohio.
- ODMH should develop a statewide, speakers bureau of consumers who are doing well and are willing to tell their story.
- Stigma can also be reduced through more interaction of the community with consumers (See Community Involvement).

Peer Support

Mental Health consumers can and do share their experiences of living with a serious mental illness. The more that people have in common, the more they understand and support each other on issues, experiences shared, and problems faced.

Consumers get better not only with the help of traditional mental health services. They get better in many environments and with the support of many different groups or individuals. Fellow consumers who are getting better can do much to support and help others with their recovery.

People with chronic mental illness generally have significantly smaller social networks (Pattison, et. al., 1975; Cohen & Sokolovsky, 1978; Hamer, 1981), and small social network size has been associated with re-hospitalization (Cohen & Sokolovsky, 1978).

Dependent, rather than reciprocal relationships have also been predictors of readmissions (Cohen & Sokolovsky, 1978). Dependent relationships may decrease self esteem and increase stress (Sokolove & Trimble, 1986).

A study conducted at Case Western Reserve University (Biegel & Tracy, 1994) found that while professional social skills and self esteem intervention groups were relatively successful, implementation of intervention activities by case managers to increase social support for each client had only limited success. Consumer-run activities, including peer support groups, encourage the development of reciprocal relationships, enhancing self-esteem and independence. The focus of self-help is voluntary mutual aid by peers. Its purpose can be personal support or social change. "Self-help enables people to use their own resources to gain control over their lives. Self-help supports recovery and leads to empowerment." (Spaniol, et al., 1994.)

According to the New York State Office of Mental Health, "A growing number of mental health programs across the country are experimenting with approaches that incorporate recovering mental health consumers as service providers. ... Underlying these efforts is the belief that consumers, due to their personal experiences with mental illness and the mental health system, can make unique contributions to enhance mental health effectiveness." Needs filled by consumers are identified as, "being a role model for recovery, providing practical strategies for coping with symptoms and negotiating service systems, and assisting in the development of self-help networks." They also suggest that "collaboration with consumer colleagues will enhance professional mental health workers' understanding of recovery and sensitivity to issues such as stigma." (Surles, 1994)

In a collaboration with the Albert Einstein College of Medicine, the Mental Health Association in New York State, and Bronx Psychiatric Center, the New York State Office of Mental Health integrated consumer "peer specialists" into an intensive case management program (ICM) for a three-year research demonstration funded by NIMH and the Center for Mental Health Services. Researchers hypothesized that peer specialist involvement would have a beneficial impact on five client outcome areas: Self-image and outlook, ICM, program engagement, social support, quality of life, and community tenure. Study finding "provide strong evidence that the integration of recovering consumers into ICM teams was associated with enhanced service effectiveness," and all five client outcome areas favored clients in the ICM-peer specialist group, with the quality of life area most strongly impacted. "Clients in the ICM-peer specialist group experienced greater increases in satisfaction in several life domains (living situation, finances, personal safety, physical health/medical care)," and reported "a decrease in the number of major problems experienced, the only client group to do so."

The report states that of all three groups involved in the study, the ICM-peer specialist clients ranked first in improvement for 21 out of the 29 measures, supporting the conclusion that the incorporation of consumer-providers into ICM programs can enhance service effectiveness. "The evidence suggests that consumer-providers do in fact bring unique characteristics and

contributions to the mental health workplace that are non-reproducible by non-consumer paraprofessional workers, and that these unique factors are what make the difference in clients' lives." (Surlles, 1994)

Recommendations:

- The Ohio mental health system should support consumers helping other consumers recover.
- There should be exploration to see if Medicaid would fund peer support work, and boards and agencies should either contract with consumer groups for peer support services or hire consumers as part of the treatment teams as peer specialists.
- ODMH should research the possibility of providing "personal assistance" for people recovering from mental illness as a Medicaid funded program, as is provided for other disabled people.
- ODMH should strongly encourage every mental health board to fund at least one consumer group and all hospitals should have consumer peer support groups.
- ODMH should provide capital, and local boards should provide operating funds for drop-in centers annually.

Family Support

Anthony (1993) writes that having people who believe in and stand by the person in need of recovery is a basic need that is universal to recovery. As Johnson (1994, P.7) has noted, "Families [often] become the last resort as connections with the rest of the social world."

A person with mental illness often has (at least in the early stages of the illness) some available support system consisting of family and/or friends. Living in and interacting with a familiar community and a family/friends network helps create the necessary normalization process required for recovery. Some consumers choose not to seek out peer support from other consumers, but all need a social network of support.

The family is still the basic social support in our society. Families should be viewed as natural potential providers of support in recovery for sons, daughters, husbands, wives, siblings, and parents with mental illness. "Most families in the world [according to international studies of "expressed emotion" or EE], regardless of the symptomatic or functional characteristics of their ill loved ones, show affectionate support, tolerance, and acceptance." (Hatfield & Lefley, 1993, p. 81).

Some of the problems families face when first confronted with mental illness in a relative include: lack of information about the illness, its effects and prognosis; lack of knowledge of how to help their relative access treatment and financial benefits; lack of knowledge about how

to encourage recovery; and feeling of frustration at being shut out from obtaining that information, which is so vital to productive family functioning. Many writings by consumers confirm their awareness of this situation (1994, p. 11) says, “How families understand mental illness, and the nature of professional help offered them, Shapes the care-giving process.”

As Johnson (1994, p. 78) states, “We all know about dysfunctional families. ... Nevertheless, to maintain perspective, we must also realize that for the majority of people who develop mental illness, it is the family that is left with and willing to take responsibility for care.” Research suggests that reestablishing connections, decreasing conflict and moderating intensity among family relationships may increase support to all family members (Brown, Birley & Wing, 1972). “The caring family,” Hatfield & Lefley (1993, pp. 187-188) say, “provides the bedrock to which the person can always turn for continuity, support, and most of all, a sense of permanent commitment to his or her welfare.”

Recommendations:

- Provide supportive families/significant others with the diagnosis, education, psycho-education and/or family consultation to allow them to “help without being intrusive, facilitate without being controlling, support without domineering,” and “help reduce relapse and facilitate recovery.” (Beale, 1994)
- Confidentiality issues must not be misused by mental health professionals in such a way as to prevent necessary care which is in the best interest of the consumer. Families/significant others must know how to deal with suicidal threats and actions, violent behavior, and how to provide an accommodating environment that promotes empowerment and recovery.
- Providers of mental health services must include significant others in developing treatment plans, especially for consumers living in their homes, unless forbidden by the consumers.
- ODMH and local boards should continue to fund family education programs so families can learn about mental illnesses, medications, treatments, family problem solving, improving communication with their ill family member, and how to be enabling and supportive or recovery.

Community Involvement

“People should not live within service systems but within communities.” Curtis (1994) reports that this view of the Canadian Mental Health Association provides the basis for their community living framework in which “the goal is to increase and maintain self-help, family and general community support. Professionals help each individual to intentionally develop and sustain a personal support network which may be augmented, but not dominated, by formal mental Health services.”

According to Walsh & Toomey (1994), “it is speculated that SMD clients can only achieve functional independence to the extent that they can develop natural social supports in the community to augment the supportive roles of social workers and other health care professionals.” Stein & Cislo (1994), state that their study “underscores the importance of social context in community interventions. ... A ‘normalized’ role ... in a legitimate setting ... strongly influenced individual behaviors and interpersonal transactions.’ Recommendations of Biegel & Tracy (1994) include; “the development of countywide strategies to involve churches, ethnic, fraternal and social organizations and other community-based organizations in the care of persons with mental disability.”

Normalization and recovery should be encouraged by making available to consumers opportunities to be involved in community activities. Sullivan (1994) includes affiliation with the community as one of the natural inclusionary processes which create an enabling social niche. Enabling niches are not stigmatizing and provide access to different perspectives, so that the consumers’ social world is less restricted. “People in enabling niches are not totally defined by their social category, they are accepted as having valid aspirations and attributes apart from their category.’ (p. 12)

Social integration has been defined as affording people with psychiatric disabilities the opportunity to participate in all aspects of community life—living in typical housing, working in the usual employment settings, learning in community schools, and worshipping and seeking recreation along with other community residents. (Reidy, 1992.) It also means that the mental health system should direct its efforts and resources toward maximizing contact and mutual support between consumers and a wide range of potential friends and supporters. (Carling, 1994.)

Curtis (1994) also tells us, “At its core, social integration is not a program; it is opportunity, welcome, and inclusion. While many individuals are very adept at identifying and meeting their social needs, many other want and need help. Although mental health services can increase their attention to helping people build a strong network of supporting relationships, providers must be careful not to create yet one more program for shaping a person’s life according to an external set of ideals.”

Recommendations:

- Consumers need to be included in community activities and have access to local resources for support and enrichment as their interests and abilities dictate. Community Mental Health Centers (CMHCs) should provide opportunities for this to occur.
- Memberships in YWCA/YMCA or participation in some of their activities; opportunities to do volunteer work in libraries, churches, hospitals and other institutions; attendance at and/or participation in community activities such as art shows, concerts, street fairs, and lectures should be facilitated by CMHCs providing transportation (and tickets when needed).

- Education classes for local clergy and civic leaders and coordination with local churches and social organizations would provide access to activities and greater assimilation of consumers into the community.

Access to Resources

For a person to function more fully in this world, it is necessary to have a access to a large number of people, places, and things. People who have experienced a long term psychiatric illness have limited resources and limited access to resources. Specifically, they do not have private transportation or money for public transportation. Housing is often substandard and located in less desirable neighborhoods. What little money that a consumer has can be mismanaged, simply because of lack of experience. A number of actions could be taken to improve consumers' access to and proper usage of resources.

Recommendations:

- Provide training for consumers in how to work effectively with human service systems, and how to access benefits for which they may qualify (GA, SSO, SSDI, PASS, etc.)
- Provide training for consumers in money management.
- Create cross-systems accessing of financial support for consumers in one location (“one-stop-shop”) in all communities.
- Provide cross-systems training/networking to SSA, ORSC, Human Services and other agency personnel on working with consumers.
- Mental health providers from state to local level should join with consumer and family advocates to work toward the removal of Social Security, Human Services, and insurance disincentives to work.
- Increase involvement of case managers in assuring that consumers receive benefits to which they are entitled and continuing assistance when needed to ensure that they retain those benefits.
- Ensure a wide range of housing options in all board areas to provide accessibility to appropriate levels of care and community activities as chosen by the consumer.
- Provide funding for transportation options (purchase of vehicles) to community drop-in centers and peer support programs to ensure accessibility of available supports and enrichment, opportunities for socialization, and participation in community activities.
- CMHCs should publish a guide to services and programs available at their center and provide a copy to each consumer along with a full explanation during their first interview of the help available to them.

Education

The initial pursuit of education by consumers is often interrupted by the onset of the illness. The need to resume education in recovery is critical for many consumers. Learning needs to be defined as a lifelong individualized process. This education can range from college to ceramics. A person who is learning is actively interacting with the world. Education provides the opportunity for being challenged, for working toward a goal, and in some instances goal achievement/success. This process allows an individual to grow and have more control over his/her life.

Jobs are highly related to training and education. Some consumers do not have a high school diploma or GED. This is a minimum requirement for many jobs. Classroom instruction for consumers should be a high priority.

Consumers also need more education about their illness, medications, and options for rehabilitation. Recovery should be stressed from the time of initial diagnosis to reduce the loss of self-esteem and increase the sense of empowerment.

Recommendations:

- Optional sources of instruction and training for consumers should be made available.
- Opportunities to complete the GED should be provided.
- Some consumers are capable of and interested in attaining higher education or job training. Not only should the Social Security Plan for Achieving Self Sufficiency (PASS) and other financial supports be actively promoted and accessed, but on-campus supports for college student consumers should be developed.
- Ongoing support services should be provided to help consumers to be successful in their educational/vocational environment.
- More comprehensive disclosure by mental health professionals to consumers is needed to educate consumers about their illnesses and medication, including expected effects, possible interactions, and responsible role in their own recovery.

Clinical Roles and Relationships

The goals of a recovery-oriented mental health system and the services required to meet them, stated by Spaniol, Keohler & Hutchinson (1994), include: reducing symptoms and exploring and understanding feelings, thoughts, values, goals and roles that enhance recovery through treatment; assisting people to be successful and satisfied in chosen roles and setting with the least amount of situations that interfere with recovery through crisis intervention; accessing services that facilitate recovery through case management; advocating for improved services and

eliminating barriers to recovery through rights protection and advocacy; promoting and supporting one's own recovery and that of peers with mental illness through self-help; meeting survival needs basic to recovery through basic support; and enhancing quality of life through enrichment.

The values of a recovery-oriented mental health system, according to Spaniol, et al., are: empowerment (creating a personal vision and having the confidence to move toward it); client choice (people making their own decisions about how to lead their lives); client involvement (participating in the process by which decisions are made that affect one's life); community-focus (building on existing connections); and client strengths (watering the flower, not the weeds).

The medical model of treatment is a top-down method where major decisions are made by the medical doctor or other clinical or administrative people. This model puts the ownership of wellness in the hands of the clinician, thus the consumer becomes a powerless and impotent recipient of treatment. In the interactive model, decisions are made after sufficient information has been gathered from all persons involved in the program or area of concern. In this model, discussion and input which forms the basis of resultant decisions is sought from all. The interactive model gives the consumer ownership and responsibility for wellness in a shared relationship with clinicians. Thus the consumer works toward recovery in partnership with the clinician.

According to Anthony (1993), personal support, the development of new meaning and purposes in one's life, and "regaining the belief that there are options from which one can choose—a belief perhaps even more important to recovery than the particular option one initially chooses, "are critical to recovery." Anthony states, "Recovery-oriented mental health systems must structure their settings so that recovery 'triggers; are present'" (p12). These "triggers" must not, however, be expected to always meet the current need and readiness of every consumer. Denial and strong emotion are a part of the recovery process at times and must be accepted in a non-stigmatizing and understanding environment and not routinely characterized as nonfunctional.

Consumer driven assertive case management focused on the acquisition of resources is viewed by Sullivan (1994) as one of the community-based services that appears to have the greatest potential to aid the recovery process. Any approach which provides normalization experiences enhances recovery. "Supported housing and vocational programs, based on the choose, get, and keep model of helping, provide the opportunity for individuals to inhabit a meaningful niche and perform basic social roles. ... Self-help groups and consumer-run programs foster empowerment. ... For families, the opportunity for loved ones to assume these active responsibilities and to escape niche entrapment significantly reduces the burden they experience." (pp 12-13).

The basic premise is that "the ability of the consumer to be successful is viewed as dependent on the supports available to a person, not the nature of the person's illness. ... Here the view is of a person as permanently ill." (Sullivan, 1994, p.13).

This approach, while not widely practiced in depth in the actual treatment of mental illness, is consistent with the basic conceptual framework of social work practices and psychosocial rehabilitation principle, e.g., ecological/systems models and strengths/competence approaches (Cnaan, Blankertz, Messinger & Gardner, 1989; Wintersteen, 1986).

One of the most notable finding in the recent study *Services In Systems; Impact On Client Outcomes* was the high impact on outcomes of clients; feelings of empowerment concerning their services and the degree to which these services met their expressed needs. Clients; feelings of empowerment were directly related to outcomes regardless of the amount of services received (Roth, et.al. 1994).

Recommendations:

- Accurate, appropriate clinical diagnosis is essential to recovery and must be assured. Consumer-and family/significant other-reported history of symptoms, past diagnoses and medication history (including positive and negative reactions to medications) should be given careful attention.
- Assertive community treatment consisting of group-based treatment geared toward socialization and daily living skills education should be available in all communities.
- Assertive case management focused on assisting consumers in the acquisition of resources should be provided by every community mental health center.
- Consumers and family/significant others as appropriate should be included in treatment planning, program planning and evaluation of services at all levels of the mental health system.
- A basic curriculum for training personnel in the mental health system in a recovery oriented perspective needs to be developed. Mental health professionals, consumers and family members should collaborate in the development of this curriculum.
- Clinicians should be provided with special training by human resource development specialists in the interpersonal skills necessary to provide personal support that is trusting, empathic and facilitative of recovery.
- The mental health system needs to ensure orientation of new clinical staff concerning consumer is, recovery, the appropriate role of families/significant others, and the needs of families who are actively involved in providing care and support. Part of the training should include requiring mental health personnel to experience the frustration to the necessary paperwork in the system and in accessing benefits.
- Crisis response teams should be included in training required for other staff involving consumer and family perspectives.

- At the state and/or local community level, records should be maintained of training for staff done by or with consumer.
- A process should be developed for consumers to become certified to train professional and paraprofessional staff.
- Mental health patients should retain the right to change the person who has control of his/her treatment while institutionalized.
- Individually developed coping strategies must be encouraged, strengthened and supported to enhance the recovery process.
- Consumers must be empowered by the treatment staff to provide information on the specific strengths that enable individuals to respond, benefit, and grow. A focus on treatment models and support systems may ignore these critical factors.
- Clinicians need to recognize the peer support/peer specialist model as a positive enhancement of treatment for some consumers and learn to use this model in the overall treatment plan with the consumer.

Summation

One recovering consumer encapsulated the recovery concept with a personal observation: “E used to think my goal was to become like I was before the illness. Then I realized that I was older, that I had experienced a lot and learned a lot, even from my illness, and my goal became to discover who I am now and make the best future for myself that I can.” The goal of the mental health system should be to enable such discovery and assist the consumer in the attainment of reasonable personal lifetime goals. We must never forget that recovery occurs from within.

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